



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

Marcia Curtiss
CSM Serenity, LLC
61 Sheldon Ave., SE
Grand Rapids, MI 49503

RE: License #: AL030393311
Investigation #: 2026A0581006
Macatawa East

Dear Marcia 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 feel free to 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 (517) 335-5985.

Sincerely,

A handwritten signature in black ink that reads "Cathy Cushman". The signature is written in a cursive, flowing style.

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	AL030393311
Investigation #:	2026A0581006
Complaint Receipt Date:	12/22/2025
Investigation Initiation Date:	12/22/2025
Report Due Date:	02/20/2026
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. ALLEGATIONS

	Violation Established?
Direct care staff did not administer Resident A's Memantine dementia medication in December 2025.	Yes
Direct care staff administered Resident B's Seroquel medication to Resident A in December 2025	No
Direct care staff did not provide Resident A with a dose of his Morphine medication when he left the facility to visit a friend on or around 12/13/2025.	Yes

III. METHODOLOGY

12/22/2025	Special Investigation Intake - 2026A0581006
12/22/2025	Special Investigation Initiated – Telephone – Interview with Complainant.
12/22/2025	APS Referral
12/23/2025	Contact - Document Sent - Email to APS
12/23/2025	Contact - Telephone call made - Voicemail left with APS
01/05/2026	Inspection Completed On-site - Interview with staff, residents, and obtained documentation. Interview with Administrator.
01/06/2026	Contact - Document Sent - Sent Administrator an email
01/07/2026	Contact - Telephone call made - Left voicemail with Administrator.
01/08/2026	Inspection Completed-BCAL Sub. Compliance
01/08/2026	Contact - Document Sent - Sent email to licensee.
01/09/2026	Contact – Document Received – Email from Administrator.
01/13/2026	Contact – Document Received – Email from Administrator.
01/28/2026	Exit conference with licensee designee, Marcia Curtiss.

ALLEGATION:

- **Direct care staff did not administer Resident A's Memantine dementia medication in December 2025.**
- **Direct care staff administered Resident B's Seroquel medication to Resident A in December 2025.**
- **Direct care staff did not provide Resident A with a dose of his Morphine medication when he left the facility to visit a friend on or around 12/13/2025.**

INVESTIGATION:

On 12/22/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 12/13/2025, Resident A left the facility for an overnight visit with a friend, but the facility's direct care staff did not provide Resident A with his Morphine medication. The complaint alleged Resident A's Morphine medication is needed for Resident A's pain management and subsequently, he was in extreme pain. The complaint further alleged that during the week prior, direct care staff did not administer Resident A's Memantine medication, as ordered, but administered it to him the following day. Additionally, the complaint alleged direct care staff administered Resident B's Seroquel medication to Resident A; however, the complaint alleged Resident A did not take the Seroquel. The complaint alleged when Resident A informed direct care staff about the Seroquel pill, staff acknowledged it belonged to Resident B.

The complaint alleged Resident A has a traumatic brain injury (TBI) and is diagnosed with bipolar disorder, epilepsy, osteoarthritis, rheumatoid arthritis chronic pain syndrome and dementia.

On 12/22/2025, Allegan County Adult Protective Services specialist, Kathleen Woodward, documented in her email to Adult Foster Care consultant, Eli Deleon, she was substantiating for neglect because the facility's direct care staff "...didn't alert management of the errors, [Resident A] did". She documented in her email Resident A missed an evening dose of his "memory medication" with direct care staff telling him he would have to wait until the following day to take it despite the medication being in the facility. She documented in her email to Eli Deleon that the medication had not been entered into the computer for staff to dispense it to Resident A. Kathleen Woodward documented that the next day, Resident A went to the neighboring facility and spoke to the manager who instructed staff to administer it to him. Kathleen Woodward documented that if Resident A had not informed the manager then he would not have received his medication. She also documented management "... had no idea that he had been given someone else's Seroquel as staff never reported that error to them".

On 01/05/2026, I conducted an unannounced investigation at the facility. I interviewed direct care staff, Connie Pendergrass. Connie Pendergrass stated she was not working when the alleged incidents with Resident A's medications occurred. She identified direct care staff, Alexis Pruitt, as the staff working on or around 12/13/2025 when the alleged incident with Resident A's Morphine occurred. Connie Pendergrass stated she reviewed staff's communication log for 12/13/2025, which documented Resident A was not administered his Morphine medication when he left the facility for an overnight visit on that date. Connie Pendergrass stated staff are expected to package a resident's medications if the resident is going to be away from the facility during a scheduled medication time. Connie Pendergrass stated she was not aware of any direct care staff administering Resident B's Seroquel medication to Resident A.

I reviewed the licensee's document titled, "STAFF COMMUNICATION LOG" for second shift on 12/13/2023 completed by Alexis Pruitt, which documented under Resident A's notes, "OFF, Be Back tomorrow, didn't Pack Morphine Pill[sic]". The third shift notes documented Resident A was "Gone for the night". The first shift staff communication notes, dated 12/14/2025, documented Resident A returned to the facility at approximately 9 am.

During the inspection, I requested to review Resident A's Memantine medication; however, Connie Pendergrass stated it was not in the facility.

I reviewed the physician's order for Resident A's Morphine Sul Tab 30 mg ER, which documented Resident A receives one tablet by mouth twice daily. It documented the daily schedule as 8 am and 8 pm.

I interviewed Resident A who was unable to recall the specific dates he did not receive his scheduled Morphine or Memantine medication, but stated the incidences occurred in the evening in December 2025. Resident A stated at approximately 7 pm one evening, staff put his evening medications in a cup and gave them to him; however, when he looked in the cup he did not observe his Memantine pill. He stated he also had a Seroquel pill in his cup, which is not one of his scheduled medications. Resident A stated he had not been paying close attention to his pills except that evening when he noticed the errors. He stated he did not know how long he had not been receiving his Memantine medication. Resident A stated he knew there was a Seroquel pill in his cup because he had been on Seroquel before and was aware of what the pill looked like. Resident A stated he reported the errors immediately to staff, Aliyah Dykstra. He stated Aliyah Dykstra reported to him that the Memantine medication was not in the facility; however, Resident A stated he saw the medication in a tub near the medication cart. He stated Aliyah Dykstra reported to him she could not administer the medication because it had not been scanned into the facility's electronic system by daytime staff. Consequently, Resident A stated he did not receive his Memantine medication that evening. Resident A stated he spoke to another staff the following morning about the error. He stated he believes he has been receiving his Memantine medication as required since that incident.

Resident A stated he knew it was Resident B's Seroquel medication because her medication packets are in front of his packets in the medication cart. He stated he did not take Resident B's Seroquel medication and did not know what happened to the medication when he returned it to staff.

Resident A stated he did not receive an 8 pm dose of Morphine medication when he left the facility to spend the night at a friend's house in December. He stated he left the facility in the afternoon and returned to the facility the following morning. Resident A stated staff prepared his medications by putting the individual medication tablets in plastic baggies, labeling the baggies with the prescription names, and giving them to him. Resident A stated he did not realize the 8 pm dose of his Morphine medication had not been packaged until that evening. He stated when he realized the error, he contacted the facility, but staff told him it was his responsibility to remember his medications and that he would need to return to the facility to receive the medication, which he was unable to do. As a result of not receiving his scheduled evening dose of Morphine, Resident A stated he had a difficult time sleeping that evening. Resident A stated he had not had any further issues with receiving his Morphine since that incident.

I interviewed Resident B who stated she received all scheduled medications in December, as required, including her Seroquel medication. Resident B described her Seroquel medication as a brown pill and stated she received it twice a day, every day in December, as required.

I interviewed the facility's Administrator, Amanda Brenner. Amanda Brenner stated Resident A did not receive one of his evening medications, which she later identified as Memantine, because there had been an issue with Resident A's insurance and staff did not follow up with the pharmacy to ensure the medication was filled. She could not recall when she spoke to a pharmacy staff about the issue, but she stated the pharmacy employee apologized for the medication not getting refilled. Amanda Brenner acknowledged she and staff "dropped the ball" with getting Resident A's Memantine medication filled in a timely manner. Amanda Brenner stated staff, including herself and the facility's identified home manager, Keyana "Kiki" Carson, should have checked the medication administration records daily and followed up with the pharmacy to ensure Resident A did not go without it.

Amanda Brenner stated she did not believe there were any issues with Resident B not receiving her medications, as required, including her Seroquel medication. She stated Resident A did not tell any staff or management about receiving Resident B's Seroquel medication.

Amanda Brenner stated staff "forgot" to package Resident A's Morphine medication when Resident A went on an overnight visit in December. She stated, "staff just forgot." She stated Resident A called the facility and staff instructed Resident A to return to the facility to receive the medication, but "he didn't want to."

Amanda Brenner provided contact information for staff; however, she stated Aliyah Dykstra, was not currently employed by the licensee.

I reviewed Resident A's December 2025 electronic Medication Administration Record (eMAR), which documented staff, Mary Marsh, administered Resident A's morning medications on 12/13/2025. The eMAR documented staff, Alexis Pruitt, initialed the eMAR signifying she administered his 8 pm dose of Morphine Sul Tab 30 mg ER medication on 12/13; however, the eMAR documented Resident A was "OUT OF FACILITY."

The eMAR documented Resident A is to "take 1 tablet by mouth daily at bedtime" of Memantine Tab HCL 10 mg for "Cognitive communication deficit"; however, on 12/01, 12/02, 12/03, 12/04, 12/05, 12/07, and 12/08 at 8 pm he did not receive this medication because staff documented "MED NOT AVAILABLE".

On 01/08/2026, I received a copy of PharmaScript of MI GR packing slip, dated 01/05/2026, which confirmed Resident A's Memantine medication was delivered to the facility on 01/05/2026 and was available to administer the evening of 01/05.

I also received and reviewed Resident B's December eMAR, which documented Resident B received her Seroquel medication twice daily, as required. I neither identified any concerns on Resident B's eMAR nor was I able to determine if her Seroquel medication was administered to another resident.

I received and reviewed the licensee's *AFC Licensing Division – Incident / Accident Report (IR)*, dated 12/13/2025 pertaining to Resident A not receiving his Morphine, which was completed by the facility's Administrator, Amanada Brenner. The IR documented on 12/13/2025 at approximately 9 am, Resident A was leaving the facility for an overnight stay, but direct care staff, Mary Marsh, forgot to pack Resident A's 12/14/2025 8 am dose of Morphine. The IR documented Resident A called the facility at approximately 3 pm when he realized he did not have his dose for the following morning. The IR documented Mary Marsh texted the facility's home manager, Keyana Carson, who then sought instruction from Amanda Brenner. The IR documented Amanda Brenner contacted HomeMD for assistance, who instructed Amanda Brenner that as long as Resident A was back within two hours of his scheduled dose then he was fine to take it. The IR also documented Mary Marsh was "retrained on medication steps".

On 01/09/2026, I interviewed former direct care staff, Aliyah Dykstra. She stated she primarily worked in the neighboring facility; however, she was familiar with Resident A. Initially, she stated she recalled an incident in December 2025 whereas Resident A needed a medication, but it was unavailable in the facility. Aliyah Dykstra clarified during the interview that she could not recall if the medication was unavailable in the facility, or if it was available, but had yet to be scanned into the facility's eMAR system. Aliyah Dykstra could not initially recall the name of the medication, but later in the interview agreed the medication was Memantine. She also could not recall

how long the Memantine medication had been unavailable to staff to administer to Resident A. Aliyah Dykstra stated the facility's manager, Keyana Carson, is responsible for scanning medication into the eMAR system and until it is scanned into the system staff are unable to administer it to residents.

Aliyah Dykstra stated she did not recall Resident A receiving another resident's medication, including Resident B's Seroquel. Additionally, she stated she never prepared any medications for Resident A for a leave of absence out of the facility during a scheduled medication administration time. She stated she only prepared medications for other residents at a neighboring facility and needed assistance from another staff with the preparation because she was not familiar with the process. Aliyah Dykstra stated the medications were prepared by popping the medications, putting them in plastic baggies, and then writing on the baggies the medication names with the date and time the medications should be administered.

On 01/09/2026, I interviewed direct care staff, Keyana Carson, who also stated she was identified as the facility's house manager. Keyana Carson stated she was familiar with Resident A and his medications. She stated she was also aware of a couple instances where there were issues with Resident A's medications including his Memantine and Morphine medications. She confirmed Resident A went several days without receiving his Memantine medication. She stated she was expected to run daily medication reports to determine if medications are running low or were out; however, she acknowledged she did not run these daily reports because she was "busy with other things". She stated when she contacted the pharmacy regarding the medication not being in the facility and the pharmacy delivered the medication the following day. Keyana Carson stated she was aware Resident A reported receiving Resident B's Seroquel medication; however, she stated this was not reported by any staff and she could not verify the incident occurred.

Keyana Carson's statement regarding Resident A not receiving his Morphine medication in December was consistent with Amanda Brenner's statement to me. She stated Mary Marsh was scheduled to take an additional medication training for the Morphine medication error.

On 01/09/2026 and 01/14/2026, I interviewed staff, Mary Marsh. Her statement was consistent with Aliyah Dykstra's statement to me. She was not aware of any incidences relating to Resident A not receiving his Memantine medication. She also stated she was not aware of Resident A receiving another resident's medication, including Resident B's Seroquel.

Mary Marsh stated she forgot to give Resident A his Morphine medication when he went on an overnight visit on or around 12/13/2025. She stated she believed she got the medication out and had been ready to put it in a baggie like Resident A's other medications, but got distracted because it was a "hectic" day with another couple residents. She stated she had to leave the medication room in the middle of preparing Resident A's medications to assist the residents. Mary Marsh

stated that when preparing medications for a resident who will not be in the facility for a scheduled medication time she described a process of pre-setting resident medications. She stated Resident A's medications come in bubble packs and when preparing them for an outing, she pops out the medication and then puts the medication in baggies according to the time the medication should be administered. She stated for example, all of Resident A's morning medications would be in the same baggie while all his evening medications would be in another baggie. She stated staff would not provide an entire bubble pack of medication to a resident or a resident's responsible person upon the resident leaving for an outing. She stated neither the resident nor their responsible person sign any document acknowledging they are in receipt of the medications.

Mary Marsh stated Resident A left the facility after taking his morning medications. She stated Resident A called her around 2:30 pm and reported he did not receive his Morphine medication. Mary Marsh stated she contacted Keyana Carson who instructed her to tell Resident A to return to the facility so she could administer his Morphine medication. Mary Marsh stated Resident A needed to return to the facility because she was unable to leave the facility. She stated she both wrote a communication note and communicated the incident verbally to incoming staff. Mary Marsh stated she did not know if Resident A received his Morphine medication the following morning.

On 01/13/2026, I reviewed the facility's self-titled document "Medication Program", after requesting Amanda Brenner provide me a copy of the licensee's Medication Policy. Upon review of the document, I determined the policy's intention is to "...provide a medication oversight program for those residents who need medication assistance and will ensure compliance with all state and federal regulations".

I reviewed the policy's specific procedure for "Out of Building Medications". It documented, "When a resident plans TO BE OUT OF THE BUILDING, IT IS THE COMMUNITY'S RESPONSIBILITY TO ASSURE COMPLIANCE THAT THE RESIDENT RECEIVED THEIR MEDICATIONS AS PRESCRIBED BY THE PHYSICIAN". The procedure documented it was "NOT acceptable" for a resident to not receive their medications because they are out of the facility. The licensee's procedure also documented the following:

- If the resident is out of the building at consistent times or days the nurse may adjust the medications schedule to accommodate the resident to ensure they receive their medications prior to or upon return to the community when physician medication orders allow this.
- The resident and family must be informed to notify the staff when the resident will be out of the building and when they are leaving so these medications can be provided for administration when resident is out of the building.
- If a resident plans to be out of the building when medication assistance would be provided, the nurse or family will: Place the resident's medication package into a manilla folder.

- Count narcotics, if they are to be dispensed, in original container. Responsible person signs quantity on instruction sheet.
- Provide written instructions for the resident/responsible person as to times medication is to be taken.
- Upon the resident's return to the community, ensure that all medications were taken/returned by resident by verifying the count on the medication release form.
- Report any variance in the count to the director of wellness or designee.

According to Special Investigation Report #2025A0357025, dated 04/09/2025, the facility was in violation of Adult Foster Care (AFC) administrative rule, 400.675(1). This violation was previously cited under AFC rule 400.15312(2), which is no longer in effect following the implementation of the revised Adult Foster Care rules effective November 3, 2025. The prior violation established that on 02/09/2025, a resident failed to receive prescribed medication, as evidenced by the discovery of six different loose pills in the resident's chair. The facility's approved Corrective Action Plan (CAP), dated 04/15/2025, documented staff received an in-service on the requirement to watch residents take their medication before leaving them.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	<p>Despite Resident A's statement that he received Resident B's Seroquel medication in December 2025, there was insufficient supporting evidence to establish a violation of this rule.</p> <p>However, based on my investigation, which included interviews with multiple direct care staff, Resident A did not receive his prescribed Memantine Tab HCL 10 mg for cognitive communication deficit at 8 pm on 12/01, 12/02, 12/03, 12/04, 12/05, 12/07, and 12/08 because staff documented it was not available in the facility for administration on those dates.</p> <p>Additionally, Resident A did not receive his 8 pm dose of Morphine Sul Tab 30 mg ER on 12/13/2025 after leaving the facility for an overnight visit with a friend. Direct care staff, Mary Marsh, acknowledged she forgot to send the medication with Resident A after she became distracted by other residents while preparing his medications.</p>
CONCLUSION:	<p>REPEAT VIOLATION ESTABLISHED</p> <p>SEE SIR 2025A0357025, DATED 04/09/2025, CAP DATED, 04/15/2025</p>

APPLICABLE RULE	
R 400.675	Resident medications.
	<p>(5) A licensee, administrator, or direct care staff shall ensure that the resident or the individual who assumes responsibility for the resident has the appropriate information, medication, and instructions when the resident is out of the facility but still requires medication during that period.</p>
ANALYSIS:	<p>Based on my investigation, on 12/13/2025, direct care staff, Mary Marsh, did not ensure Resident A or the individual who assumed responsibility for Resident A, received his 8 pm dose of Morphine Sul Tab 30 mg ER. Despite the facility having a medication policy that specifies how direct care staff are to provide medications to residents when they are out of the facility during a scheduled medication administration time; the facility's staff preset his medications. Medications cannot be preset and must remain in their pharmacy labeled containers at all times.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

01/28/2026

Cathy Cushman
Licensing Consultant

Date

Approved By:

Dawn Timm

01/29/2026

Dawn N. Timm
Area Manager

Date