GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 21, 2026

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

RE: License #: AL410398969
Investigation #: 2026A0583047
Willow Creek - West

Dear Mrs. Curtiss:

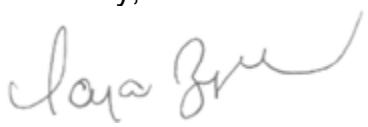
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL410398969
Investigation #:	2026A0583047
Complaint Receipt Date:	07/08/2026
Investigation Initiation Date:	07/09/2026
Report Due Date:	08/07/2026
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 - West
Facility Address:	1011 28th St. SE Grand Rapids, MI 49507
Facility Telephone #:	(616) 432-3074
Original Issuance Date:	11/02/2020
License Status:	REGULAR
Effective Date:	05/02/2025
Expiration Date:	05/01/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Staff do not adequately manage Resident A's ostomy supplies.	No
Additional Findings	Yes

III. METHODOLOGY

07/08/2026	Special Investigation Intake 2026A0583047
07/09/2026	Special Investigation Initiated - Telephone
07/09/2026	APS Referral
07/15/2026	Inspection Completed On-site
07/21/2026	Exit Conference Licensee designee Marica Curtiss

ALLEGATION: Staff do not adequately manage Resident A's ostomy supplies.

INVESTIGATION: On 07/07/2026 the above complaint allegation was received from the BCAL online complaints system. The complaint was assigned for my investigation 07/08/2026. The complaint stated that, *'(Resident A) has had multiple ER visits r/t ostomy supply issues despite staff being educated and worked with to avoid needless ER transports/ ER trips just to supply/apply an ostomy bag.'* The complaint further stated that it, *'seems RS staff are unable to manage care needs, ostomy supply inventory, or verify wafer & bags compatibility and this has resulted in issues for (Resident A) who keeps getting sent to ER unnecessarily.'*

On 07/09/2026 I referred the complaint allegation to Adult Protective Services via the online portal.

On 07/13/2026 I received an email from Area Agency on Aging Registered Nurse Supports Coordinator, Krista Sturgeon. The email stated the following: *'To clarify, it is not a matter of specific orders that are not being followed. The issue is that AFC cannot keep ostomy supplies in stock for Resident A. This has been ongoing issue. Despite working with staff to avoid unnecessary ER visits, it continues to be problem with most recent ER visit on 7/5/26. AFC sends her to ER to get ostomy bag applied and ER sends back to AFC home. To avoid running out, staff should be monitoring inventory and ordering more supplies when she is down to 3-4 bags. Resident A requires colostomy supplies and there are no other option to maintain her hygiene. When Resident A received her colostomy, the AFC home assured both the guardian and me that they could meet her care needs. The fact that the AFC cannot manage her ostomy supplies, in my opinion, is neglect. Resident A has been to ER for ostomy supply issues as follows:*

7/31/2025- out of supplies
11/8/2025- out of supplies, no clips for ostomy bags
1/7/2026 – out of supplies
3/11/26 – out of ostomy bags
6/6/26- incorrect ostomy supplies -wafers and bags didn't match
7/5/26- out of supplies'

On 07/15/2026 I completed an unannounced onsite investigation at the facility and interviewed Executive Director Jennifer Leak. She stated that Resident A utilizes an ostomy, and coordinating supplies has been challenging due to changes in her medical case management team and suppliers. She stated that Resident A's ostomy supply orders were previously prescribed by CareOne Home Health and last month it changed HomeNP. She stated that CareLinc previously provided ostomy supplies and this changed to Interim "last month". Ms. Leak explained that CareOne Home Health would prescribe a "10 pack" each order and Carelinc prescribes a "30 pack" which is easier for staff to monitor. Ms. Leak stated that there have been issues with suppliers delivering the incorrect "wafer" size thus adding to supply issues. She stated that despite the challenges, Resident A's ostomy bag has always been changed timely and appropriately. She stated that all medical orders relating to Resident A's Ostomy bag are followed. She acknowledged that within the past year, Resident A has been sent to the local emergency department to obtain supplies approximately six times. She stated that Residet A does not exhibit emotional duress during the emergency department visits.

While onsite I interviewed Resident A. She appeared appropriately dressed and groomed. She stated that she utilizes an ostomy bag and she is satisfied with the care she receives. She acknowledged that she was sent to the emergency department on 07/05/2026 due to running out of supplies. She stated she has not suffer emotional harm from the emergency department visits.

On 07/16/2026 I received and reviewed Resident A's Assessment Plan. The document is signed 08/01/2025 and stated Resident A requires staff assistance with toileting and "staff change colostomy bag as required".

On 07/21/2026 I completed an exit conference via telephone with licensee designee Marcia Curtiss. She stated that she agreed with the findings.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Ms. Leak stated that there have been issues with suppliers delivering the incorrect "wafer" size which as caused supply

	issues. She stated that despite the challenges, Resident A's ostomy bag has always been changed timely and appropriately. She stated that all medical orders relating to Resident A's Ostomy bag are followed. While onsite I interviewed Resident A. She appeared appropriately dressed and groomed. She stated that she utilizes an ostomy bag and is satisfied with the care she receives. She acknowledged that she was sent to the emergency department on 07/05/2026 due to running out of supplies. She stated that she has not suffered emotional harm from the emergency department visits. A preponderance of evidence does not support that a violation of the appliable rule occurred. Staff have encountered challenges with ostomy bag suppliers, however staff continue to follow medical orders adequately.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: The facility is understaffed.

INVESTIGATION: While onsite on 07/15/2026 I observed the facility's staff schedule. On 07/14/2026 from 8:00 PM until 11:00 PM, the facility was staffed with only one staff member.

Ms. Leak stated that on 07/14/2026 the facility provided care to 18 residents and from 8:00 PM until 11:00 PM, the facility was staffed with one staff. She acknowledged that residents are still awake at 8:00 PM and that it is routine for the facility to utilize only one staff member from 8:00 PM until the following morning at 7:00 AM.

On 07/21/2026 I completed an exit conference via telephone with licensee designee Marcia Curtiss. She stated that it is their policy to staff facilities with one staff starting at 8:00 PM, but she would correct the violation. She stated that she would submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to

	residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.
ANALYSIS:	The facility's staffing schedule indicated that on 07/14/2026 from 8:00 PM until 11:00 PM, the facility was staffed with only one staff member. Ms. Leak stated that on 07/14/2026 the facility provided care to 18 residents and from 8:00 PM until 11:00 PM, the facility was staffed with only one staff. She acknowledged that residents are still awake at 8:00 PM and that it is routine for the facility to utilize only one staff member from 8:00 PM until the following morning at 7:00 AM. A preponderance of evidence supports that a violation of the applicable rule occurred. On 07/14/2026 from 8:00 PM until 11:00 PM, the facility provided care to 18 residents with only one staff member present.
CONCLUSION:	**VIOLATION ESTABLISHED**

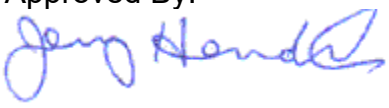
IV. RECOMMENDATION

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

07/21/2026

Toya Zylstra — Date
Licensing Consultant

Approved By:



07/21/2026

Jerry Hendrick — Date
Area Manager