GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 1, 2023

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

RE: License #: AL030393312
Investigation #: 2023A0581008
Macatawa West

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 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) 284-9730.

Sincerely,

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 #:	AL030393312
Investigation #:	2023A0581008
Complaint Receipt Date:	12/09/2022
Investigation Initiation Date:	12/12/2022
Report Due Date:	02/07/2023
Licensee Name:	CSM Serenity, LLC
Licensee Address:	61 Sheldon Ave., SE Grand Rapids, MI 49503
Licensee Telephone #:	(616) 745-4675
Administrator:	Amanda Brenner
Licensee Designee:	Amanda Brenner
Name of Facility:	Macatawa West
Facility Address:	1714 West 32nd St Holland, MI 49423
Facility Telephone #:	(616) 745-4675
Original Issuance Date:	05/10/2018
License Status:	REGULAR
Effective Date:	11/07/2022
Expiration Date:	11/06/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATIONS

	Violation Established?
Direct care staff are bringing their children to work, which is distracting staff from providing resident care.	No
There are limited snacks in the facility.	No
There is expired food in the facility fridge and cupboards.	No
Additional findings.	Yes

III. METHODOLOGY

12/09/2022	Special Investigation Intake 2023A0581008
12/09/2022	APS Referral APS received the allegations but denied investigating.
12/09/2022	Contact - Document Sent Email to APS specialist, Michael McClellan
12/12/2022	Special Investigation Initiated - On Site Interview with staff and residents.
12/13/2022	Contact - Document Sent Email to Ms. Brenner.
12/16/2022	Contact - Telephone call received Voicemail from APS, Mr. McClennan
12/28/2022	Contact - Telephone call received Interview with Administrator, Amanda Brenner.
12/28/2022	Contact - Document Sent Email to Ms. Brenner.
12/29/2022	Contact – Document Received Email from Ms. Brenner.
01/03/2023	Inspection Completed On-site Interview with staff and residents
01/11/2023	Contact – Document Sent Email to Ms. Brenner.
01/12/2023	Contact – Telephone call made. Interview with Ms. Brenner.

01/12/2023	Exit conference with Administrator/Licensee Designee, Ms. Brenner.
01/12/2023	Contact – Document Received Email from Ms. Brenner.
01/13/2023	Contact – Telephone call made Attempted re-interview with direct care staff, Kaylee Phetthongdy.
01/13/2023	Contact – Document Sent Email to Ms. Brenner.
01/27/2023	Contact – Telephone call Left voicemail with Ms. Brenner informing her of my additional findings.
01/27/2023	Contact – Document Sent Email to Ms. Brenner.

ALLEGATION:

Direct care staff are bringing their children to work, which is distracting staff from providing resident care.

INVESTIGATION:

On 12/09/2022, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged direct care staff are told it is okay to bring their children or dogs into work. The complaint alleged direct care staff, Emily Brown, brings in her children and it distracts her and other staff from focusing on resident care.

On 12/12/2022, I conducted an unannounced onsite inspection at the facility as part of my investigation. I interviewed direct care staff members Keyana Carson, Emily Brown, and Kaylee Dehaan. Ms. Carson, Ms. Brown, and Ms. DeHaan stated direct care staff members have brought their young children into work; however, all three direct care staff members denied that staff were distracted from providing care to residents when their children were brought in. They stated when staff's children were brought into work it was because of an emergency, for example, lack of daycare or school was canceled. They also denied it was a regular occurrence. Ms. DeHaan stated she brought in her nine-month-old when she was first hired, but indicated it was a training day. Ms. Brown stated she had also brought her baby in, but her baby was either kept in the Administrator, Ms. Brenner's, office or in the

medication room in an appropriate baby containment device such as a pack-and-play. They also stated Ms. Brenner has also brought her child in; however, they stated her baby is kept in her office. None of the staff I interviewed indicated any issues with animals being brought into the facility. They all indicated a resident on hospice had a visitor come in with an emotional support dog; however, they stated the dog was not aggressive and was leashed when visiting the facility.

I interviewed Residents A, B, C, and D. All the residents stated direct care staff members bring their children into work, which included infants. They indicated it was primarily the infants or babies that were brought in, but occasionally Ms. Brown would bring her young school aged children as well. None of the residents I interviewed indicated direct care staff members were not providing care to the residents because the staff's children were in the facility (e.g., medication was missed, could not assist with toileting, etc.). They also reported the infants were appropriately cared for and did not find the children's needs were compromised. Resident B indicated having the children in the facility, particularly the school aged children, was "annoying" because the children would get into the facility refrigerator and would "run around." None of the residents indicated the children caused issues with the residents like tripping, falling, or caused various types of accidents.

During the inspection, I did not observe any dogs or animals in the facility. Ms. Brown's infant was in the facility; however, her boyfriend and the infant's father, James Harris, was visiting with Ms. Brown and was providing care to the child. Mr. Harris is also an employee of the facility; however, he was not working at the time of my onsite investigation.

On 12/28/2022, I interviewed the facility's Administrator, Amanda Brenner, via telephone. Ms. Brenner stated she brings her own daughter, who is 14 months old, into the facility approximately three days a week, but she only stays in her office. Ms. Brenner denied having her daughter at the facility when she's providing direct care work. She stated there have been occurrences where children have been brought in by direct care staff, whom she indicated was primarily Ms. Brown. She stated Ms. Brown had an 11-month-old infant and young school aged children; however, she denied Ms. Brown brought her children in on a regular and consistent basis. She stated staff primarily bring their children into work when it's an emergency situation. She indicated she asked direct care staff to contact her prior to bringing their children in, which she stated direct care staff did contact her in the last couple of weeks about needing to bring their children in. She stated staff children will also come to the facility when there are facility events for the residents and/or the staff's children. She stated for example, staff children came to the facility to assist in decorating the facility Christmas tree and then again on or around 12/20/2022 when the licensee had Santa and Mrs. Claus come to hand out coats for the children. Ms. Brenner indicated Ms. Brown had brought her children in for these events, but Ms. Brown was not working at the time. Ms. Brenner denied any of the children eating facility food. She stated the children are usually eating "fast food" like Arby's or Taco

Bell when they are at the facility. Overall, Ms. Brenner denied having children in the facility took away from providing care to the residents.

On 12/13/2023, I interviewed Adult Protective Services specialist, Michael McClennan, via telephone. He stated he has observed young school aged children and infants in the facility when he has visited the facility. He indicated the children were not “doing anything bad”, but the environment “seemed chaotic.”

On 01/03/2022, I completed another unannounced onsite inspection at the facility. I interviewed direct care staff, Kaylee Phetthongdy, who stated she’s worked at the facility for approximately one month. Ms. Phetthongdy stated she had no direct or firsthand knowledge of staff bringing their children to work regularly while she was working other than direct care staff, Ms. DeHaan, brought her infant to work the first day they started working. Ms. Phetthongdy stated it had only been one time and Ms. Brenner told Ms. DeHaan she was not able to do it anymore. Ms. Phetthongdy denied anyone bringing a dog to work. She stated the only animal in the facility was a resident’s gerbil, which she showed me was kept in the living room area in a cage.

I also interviewed direct care staff, James Harris, who was working at a neighboring facility. Mr. Harris stated he’d worked for the licensee for approximately one year. Mr. Harris stated he and Ms. Brown have brought their baby in; however, he stated it only occurred if they were unable to get childcare and he stated there was always a second staff working. He denied the baby being in the facility took away from caring for residents. He stated the baby would stay in a pack in play in the medication room and he’d put cartoons on for him. He stated he would check on the baby frequently and denied the baby was not being cared for while he was working. He stated Ms. Brown has two young school aged children (approximately 8 years old and 9 years old), but he stated these children only came into work when school was canceled.

I interviewed Resident F and Resident G while at the facility. They also stated staff have brought their children to the facility while working. They described incidences where staff brought their children for work events like holiday parties with “Santa and Mrs. Claus.” Resident F and Resident G both stated it had been “a while” since staff brought their kids to work and could not recall when they were last at the facility. Neither Resident F nor Resident G indicated any of the residents did not receive care while staff’s children were in the facility. They also stated there were usually two staff working when their children were brought in.

I reviewed the *Assessment Plans for AFC Residents* for 16 residents in the facility. None of the assessment plans indicated any of the residents required increased monitoring or supervision or required two direct care staff members for assistance in mobility or personal care needs.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation, there have been several occasions where direct care staff have brought their child(ren) into the facility; however, my interviews with direct care staff and multiple residents did not indicate the children take away from providing supervision, personal care, or protection to residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Residents are hungry because they have limited snacks.**
- **There is expired food in the facility fridge and cupboards.**

INVESTIGATION:

The complaint alleged the facility's meal portions are small and if the residents are still hungry there are limited snacks to which they have access. The complaint also alleged there is expired food in the facility's cupboards and refrigerator.

On 12/12/2022, I conducted my onsite investigation around lunch time. Upon my arrival, I observed direct care staff had prepared the residents hot dogs with various condiments (e.g., mustard, ketchup, etc.), cottage cheese, apple sauce, chips, and fresh vegetables. Residents A, B, C, and D indicated they eat a lot of pizza, pasta, hot dogs, and sandwiches, but also indicated they do get fruit, veggies, and snacks. They all indicated they receive meals three times per day and two snacks. They indicated they eat dinner between 5 pm and 6 pm and breakfast is served between 6 am and 7 am.

When I reviewed the items in the refrigerator, I observed multiple leftover containers and sandwiches; however, the items were not expired. I observed fruit and vegetables in the fridge, lunch meat, condiments, and milk all of which were not expired. The facility's freezer and cupboards/pantry were also full of food and based on my review of these pantry items none of these items were expired either.

APS specialist, Mr. McClennan, stated he has completed visits at the facility at both breakfast and lunch times and observed food being served to residents. He indicated no concerns regarding the type of food or the size of portions being served to residents.

On 01/03/2023, I conducted another unannounced onsite investigation just after breakfast. I observed the items served for breakfast to consist of waffles and sausage style corndogs. Direct care staff, Ms. Phetthongdy, stated she was making meatloaf and soup for lunch. I observed the ingredients in the facility needed to make this meal. None of the residents indicated any concerns with what was served for meals, going too long between meals, or being served food that was expired or spoiled.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my investigation, which included my observations during my 12/12/2022 and 01/03/2023 onsite investigation, my interviews with direct care staff and multiple residents, there is no evidence the licensee is not providing 3 regular nutritious meals daily. I observed a variety of food in the facility's refrigerator, freezer, and cupboards. Additionally, residents stated in addition to three regular meals they also received two snacks throughout the day. There was no indication residents are going longer than 14 hours between meals either.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.

ANALYSIS:	Based on my investigation, there is no evidence residents are being served expired or spoiled food for any of their meals or snacks. While I did observe leftovers in the refrigerator during my 12/12/2022 unannounced investigation, there was no indication these leftovers were spoiled and being served to residents. Upon my review of the leftovers, there was no odor, discoloration, or change in substance indicating they were spoiled and no longer able to be eaten.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

When I conducted my unannounced onsite inspection on 01/03/2023, direct care staff, Kaylee Phetthongdy, stated she was the only direct care staff working in the facility. I confirmed Ms. Phetthongdy was the only staff working at the facility from 7 am until 7 pm after I reviewed the facility staff schedule, which she provided to me. Ms. Phetthongdy indicated there were 16 residents in the facility at the time of my onsite inspection.

On 01/06/2023, Administrator, Ms. Brenner, provided in an email a *Resident Register* confirming there were 16 residents in the facility. She stated in her email all the residents were in the facility on 01/03/2023.

On 01/13/2023, Ms. Brenner stated in an email that she came in at 11:30 am on 01/03/2023 and stayed until 9 pm to assist Ms. Phetthongdy with working.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.

ANALYSIS:	The facility was insufficiently staffed on 01/03/2023 when I determined there was only one direct care staff to 16 residents during waking hours. On 01/03/2023, direct care staff, Kaylee Phetthongdy, provided me with the staff schedule for 01/03/2023 confirming she was the only direct care staff scheduled to work at the facility from 7 am until 7 pm. She also indicated she was the only direct care staff working at the time of my onsite inspection. Though the facility's Administrator, Amanda Brenner, indicated in an email to me that she had arrived to the facility at approximately 11:30 am on 01/03/2023, she was not listed on the staff schedule as a person working on 01/03/2023 in the facility. Consequently, the facility was still insufficiently staffed from at least 7 am until 11:30 am.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my 01/03/2023 unannounced onsite inspection, I observed Resident E at the facility dining room table with approximately seven loose medication tablets on the table in front of her, while direct care staff, Kaylee Phetthongdy, was in the medication room. Ms. Phetthongdy indicated it takes Resident E a longer time to take all of her medications; however, she stated she did not have concerns the medications were being used by anyone else or that Resident E was not taking them. I observed Resident E take all her medication as I was in the dining room interviewing other residents.

APPLICABLE RULE	
R 400.15312	**Resident medications**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.

ANALYSIS:	During my 01/03/2023 onsite inspection, I observed Resident E administering her own medications unsupervised as direct care staff was in the facility's medication room. A written directive from Resident E's physician was not provided indicating she is able to self-administer medications. Subsequently, direct care staff were not supervising her at the time medications were administered to her, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Resident E was observed at the facility dining room table with approximately seven loose medication tablets in front of her while direct care staff was in the medication room. Despite Resident E taking longer to ingest her medication, a licensee shall take reasonable precautions to ensure residents take their medication and medications aren't used by other individuals within the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 12/12/2022 and 01/03/2023, I conducted two unannounced onsite investigations at the facility. During both of these onsite investigations, I did not observe any posted menus in the facility. Direct care staff, Ms. Carson and Ms. Brown, both indicated there was no menu in the facility. They both stated when they were keeping a menu staff would not adhere to it so they stopped creating one. I informed both staff a menu needed to be displayed and updated if meals changed.

Additionally, direct care staff, Ms. Phetthongdy, stated menus had not been posted since she'd worked there, which was approximately for one month.

In my interviews with residents, they also indicated there were no menus posted or available for review in the facility.

On 01/12/2023, Ms. Brenner stated menus had been posted in the facility on the downstairs refrigerator; however, residents were removing the menus and keeping

them in their bedrooms. She indicated menus were displayed on the second level in the kitchenette area.

On 01/13/2023, Ms. Brenner sent me copies of the facility's menus for December and January; however, there was no picture of the menus being displayed or posted in the facility, as I had requested.

I reviewed the menus, which indicated the meal for lunch on 12/12/2022 was goulash, corn bread, peaches, pudding, juice, and water. According to the menu, there were no changes to this meal or substitutions; despite my observations of hotdogs, chips and fresh vegetables being served that day.

Additionally, upon my review of the menu for lunch on 01/03/2023 it indicated residents were served taco salad, lettuce, tomatoes, salsa, sour cream, pineapple, juice and water. According to the menu, there were no changes to this meal or substitutions; despite my observation of meat loaf and chicken noodle soup being served that day.

APPLICABLE RULE	
R 400.15402	**Food service.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	During two onsite inspections at the facility menus were not posted and available for review. Additionally, when menus were provided by the Administrator/Licensee Designee, Amanda Brenner, they were not updated to reflect the actual meals that were served for lunch on 12/12/2022 and 01/03/2023, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/12/2023, I conducted my exit conference with Administrator/Licensee Designee, Amanda Brenner via telephone. Ms. Brenner agreed with my findings concerning the resident who was given her medication without supervision. I also attempted to conduct a follow-up exit conference with Ms. Brenner on 01/27/2023 to inform her of the additional findings; however, I was unable to reach her. Subsequently, I left her a message and sent her an email.

IV. RECOMMENDATION

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

01/31/2023

_____

Cathy Cushman — Date
Licensing Consultant

Approved By:

02/01/2023

_____

Dawn N. Timm — Date
Area Manager