GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 13, 2023

Angela Decator
CSM Alger Heights, LLC
1019 28th St.
Grand Rapids, MI 49507

RE: License #: AL410398971
Investigation #: 2023A0464025
Willow Creek - East

Dear Ms. Decator:

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,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410398971
Investigation #:	2023A0464025
Complaint Receipt Date:	02/14/2023
Investigation Initiation Date:	02/14/2023
Report Due Date:	04/15/2023
Licensee Name:	CSM Alger Heights, LLC
Licensee Address:	1019 28th St. Grand Rapids, MI 49507
Licensee Telephone #:	(616) 258-0268
Administrator:	Angela Decator
Licensee Designee:	Angela Decator
Name of Facility:	Willow Creek - East
Facility Address:	1019 28th St. SE Grand Rapids, MI 49508
Facility Telephone #:	(616) 745-4675
Original Issuance Date:	08/05/2020
License Status:	REGULAR
Effective Date:	02/05/2023
Expiration Date:	02/04/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL/ALZHEIMERS/AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff have not been trained in medication administration. As a result, residents have been given the wrong medication.	No
During the weekend of 02/13/2023, Resident A's Norco, pain medication went missing.	Yes

III. METHODOLOGY

02/14/2023	Special Investigation Intake 2023A0464025
02/14/2023	Special Investigation Initiated - Telephone Bridget Lutzke, Transitional Director
02/27/2023	APS Referral Centralized Intake, DHHS
02/27/2023	Inspection Completed On-site Angela Decator (Licensee Designee) Tasha Sherman (Staff)
03/06/2023	Contact-Documents received Facility Records
03/06/2023	Contact-Telephone call made Makiyah Hampton, Staff
03/06/2023	Contact-Telephone call made Ebony Patterson, Staff
03/13/2023	Exit Conference Angela Decator, Licensee Designee

ALLEGATION: Facility staff have not been trained in medication administration. As a result, residents have been given the wrong medication.

INVESTIGATION: On 02/14/2023, I received an anonymous, online BCAL complaint which alleged facility staff are not trained in medication administration. As a result, residents have been administered the wrong medications. The complaint also alleged that Resident A had missing narcotics the weekend of 02/13/2023.

On 02/14/2023, I exchanged emails with transitional director, Bridget Lutzke. Mrs. Lutzke stated she is currently on vacation and will be returning next week. She stated licensee designee, Angela Decator has information regarding the complaint.

On 02/27/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 02/27/2023, I completed an unannounced, onsite inspection at the facility. I interviewed Ms. Decator. Ms. Decator stated the facility is their memory care unit. All of the residents have been diagnosed with dementia. Ms. Decator stated there is not a resident in the memory care unit who would be able to be interviewed. Ms. Decator stated all staff complete an informational, online medication administration training upon hire. Once the training is complete, the staff take a test to see if they retained the medication administration training. New staff also spend time shadowing the medication technician on how to administer resident medication. Once the new staff are competent at administering medication, they are put on a medication cart to work by themselves.

I then interviewed facility staff, Tasha Sherman. Ms. Sherman stated staff hired to administer resident medication are provided “hands on” training. Ms. Sherman stated she does most of the staff training on medication administration. Once it is apparent new staff are ready to administer resident medication, they are then assigned a medication cart to work independently. Ms. Sherman stated the training can take three days or a week until staff are comfortable to be on their own. Ms. Sherman provided a demonstration of resident online medication administration record (MAR). She pulled a few residents. The MAR reflected residents are administered their medication as prescribed.

On 03/06/2023, I received and reviewed examples of staff training verification for medication administration, specifically the MALA Med Admin Test for AFC facilities. The medication administration exams were received for staff, Elyse Buitur. Both staff received a 95% on the exam.

On 03/06/2023, I contacted staff, Makiyah Hampton. Ms. Hampton stated she was a “med tech” at the facility. Ms. Hampton stated she was trained on how to administer resident medication by Tasha Sherman and Elyse Buitur. Ms. Hampton stated both were “great” at their jobs. Ms. Hampton stated she trained for three full days prior to being put on her own medication cart. Ms. Hampton stated once she was on her own cart, she could always go to Ms. Sherman and Ms. Buitur for questions.

On 03/06/2023, I spoke to former staff, Ebony Patterson by telephone. Ms. Patterson confirmed staff are provided hands-on training for medication administration. Ms. Patterson stated her training was brief, as she was previously a medication technician at another AFC facility.

On 03/13/2023, I completed an exit conference with Ms. Decator. She was informed of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	On 02/14/2023, it was alleged that facility staff are not being trained in medication administration. As a result, residents have been administered the wrong medications. Facility staff, Angela Decator, Makiyah Hampton, Ebony Patterson, and Tasha Sherman reported staff are trained in medication administration. Resident Medication Administration Records reflect residents are administered their medications as prescribed. The MALA Administration Test for AFC facilities indicated staff are trained prior to administering resident medications. Based on the investigative findings, there is insufficient evidence to support a rule violation that staff are not trained in medication administration.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: During the weekend of 02/12/2023, Resident A's Hydrocodone medication went missing.

INVESTIGATION: On 02/27/2023, an unannounced onsite inspection was completed at the facility. I interviewed Ms. Decator. Ms. Decator stated she was not working the weekend of 02/12/2023 but was aware of the incident. She stated Resident A is prescribed Hydrocodone 5-325mg as needed for pain management. Ms. Decator stated staff count locked narcotic medication before and at the end of each shift. Prior to 02/12/2023, all of Resident A's Hydrocodone was accounted for. On 02/12/2023 at 3:00 pm staff, Makiyah Hampton and Pamela Robinson completed the narcotic count. All of the medication was accounted for. At 11:00 pm, Ms. Robinson and Ebony Patterson counted the narcotics. All of the medication was accounted for. At 3:00 am, Ms. Patterson went to administer Resident A her Hydrocodone. When she unlocked the medication the hydrocodone "bubble pack" was missing as well as the narcotic count sheet. Ms. Patterson immediately contacted Ms. Decator and informed her of the missing medications. Ms. Decator

stated when Ms. Hampton and Ms. Robinson were confronted about the missing Hydrocodone, both staff quit immediately.

I then interviewed Ms. Sherman, individually. Ms. Sherman stated she came in the morning of 02/13/2023. When she arrived, Ms. Patterson informed her of the missing medication. Ms. Sherman stated the Hydrocodone was never found. Ms. Patterson stated this was the first incident of missing medications. Ms. Sherman then provided access to the medication cart. There was no narcotic log for 02/12/2023.

On 02/27/2023, I reviewed the incident report completed by staff on 02/13/2023, regarding the missing Hydrocodone. The IR was completed by Ms. Patterson. Ms. Patterson stated that she went to administer Resident A her Hydrocodone at 3:00 am. She discovered the medication and count log was missing. Ms. Patterson immediately contacted Ms. Decator.

On 03/06/2023, I spoke to Ms. Hampton by telephone. Ms. Hampton stated she was working on 02/12/2023 and completed the narcotic count with Ms. Robinson. Ms. Hampton stated all of Resident A's Hydrocodone was accounted for and documented. Ms. Hampton stated she did not need to administer Resident A her hydrocodone during her shift. Ms. Hampton heard the medication went missing after her shift. Ms. Hampton stated she had nothing to do with the missing medication, but the other staff blamed her for it. Ms. Hampton stated she quit and no longer works at the facility.

On 03/06/2023, I spoke with Ms. Patterson by telephone. She stated she was the staff person who went to administer Resident A's Hydrocodone on 02/13/2023, as she expressed being in pain. When Ms. Patterson opened the medication cart the hydrocodone and log were missing. Ms. Patterson immediately reported the missing medications to her supervisor. Ms. Patterson stated Resident A was not given any Hydrocodone as the medication was gone.

On 03/13/2023, I completed an exit conference with Ms. Decator. She was informed of the investigation findings and recommendations. Ms. Decator stated she understood the rule violation and stated a corrective action plan would be submitted.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	On 02/14/2023, it was alleged that Resident A's narcotic pain medication went missing the weekend of 02/13/2023.

	Facility staff Angela Decator, Makiyah Hampton, Ebony Patterson, and Tasha Patterson reported that on 02/12/2023 while two other staff were working, Resident A's Hydrocodone 5-325 mg was missing. The narcotic count log was also missing. As a result, Resident A was not given her PRN medication to address her pain. Based on the investigative findings, there is sufficient evidence to support a rule violation that Resident A's medication went missing.
CONCLUSION:	**VIOLATION ESTABLISHED**

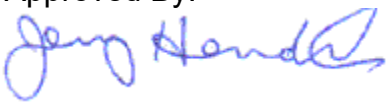
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the licensing status remain unchanged.

03/13/2023

Megan Aukerman Date
Licensing Consultant

Approved By:



03/13/2023

Jerry Hendrick Date
Area Manager