GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2023

Miranda Cockrell
CSM Alger Heights, LLC
1019 28th St.
Grand Rapids, MI 49507

RE: License #: AL410398969
Investigation #: 2023A0464028
Willow Creek - West

Dear Ms. Cockrell:

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 #:	AL410398969
Investigation #:	2023A0464028
Complaint Receipt Date:	03/02/2023
Investigation Initiation Date:	03/02/2023
Report Due Date:	05/01/2023
Licensee Name:	CSM Alger Heights, LLC
Licensee Address:	1019 28th St. Grand Rapids, MI 49507
Licensee Telephone #:	(616) 258-0268
Administrator:	Miranda Cockrell
Licensee Designee:	Miranda Cockrell
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:	05/02/2021
Expiration Date:	05/01/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL/AGED/ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not administer Resident A's Norco medication.	Yes

III. METHODOLOGY

03/02/2023	Special Investigation Intake 2023A0464028
03/02/2023	APS Referral Referral Came From APS
03/02/2023	Special Investigation Initiated - Telephone Bryan Kahler, Kent APS
03/03/2023	Contact-Telephone call received Bryan Kahler, Kent County APS
03/13/2023	Inspection Completed On-site Bridget Lutzke (Care Cardinal Administration), Angela Decator (Licensee Designee)
03/13/2023	Contact-Document received Resident A's Facility Records
04/10/2023	Contact-Phone call received Bridget Lutzke, Care Cardinal Administrator
04/13/2023	Contact-Document received Resident A's MAR
04/17/2023	Exit Conference Miranda Cockrell, Licensee Designee

ALLEGATION: Staff did not administer Resident A's Norco medication.

INVESTIGATION: On 03/02/2023, I received a complaint from Adult Protective Services (APS) that stated Resident A is currently under the care of Hospice. Resident A has a diagnosis of hypertensive heart disease with heart failure and chronic kidney disease. Resident A is not able to provide any care to herself. Over the weekend Resident A had been crying out in a lot of pain. Facility staff contacted the Hospice nurse, and it was recommended staff administer Resident A Norco for pain. On 02/27/2023, medical records showed that staff did not administer any Norco pain medication to Resident A. Hospice was informed facility staff did not

have enough time to put the medication order in. As of 03/01/2023, Resident A still has not received her Norco medication.

On 03/02/2023, I spoke to Kent County Adult Protective Services worker, Brian Kahler to coordinate the investigation. Mr. Kahler stated he called licensee designee, Angela Decator. Ms. Decator informed Mr. Kahler that Hospice sent the prescription to the pharmacy on 02/27/2023. Ms. Decator stated the pharmacy did not fill the order; therefore, they could not administer the medication. Ms. Decator stated Resident A was administered Morphine on 03/01/2023 to address her pain.

On 03/03/2023, I received a phone call from Mr. Kahler. Mr. Kahler stated he was just informed Resident A passed away. Mr. Kahler stated he spoke with both Resident A's guardian and the Hospice nurse. Both expressed concern regarding Resident A not receiving her medication for pain management. Hospice informed Mr. Kahler that Resident A passed away from natural causes. Mr. Kahler stated he would be closing his investigation.

On 03/13/2023, I completed an onsite inspection at the facility. I interviewed licensee designee, Angela Decator and Care Cardinal Administrator, Bridget Lutzke. Both stated staff contacted the Hospice nurse on Friday, 02/24/2023 as Resident A began crying out in pain. The Hospice nurse placed an order with the pharmacy for Resident A to be administered Norco for pain management. Over the weekend the prescription was "lost", and Resident A was never administered the Norco. The Hospice nurse came to the facility on Monday, 02/27/2023 and realized Resident A hadn't been given the Norco. The nurse discontinued the Norco prescription and prescribed Resident A Morphine to address her pain. Ms. Decator and Ms. Lutzke stated Resident A passed away during the night of 03/02/2023.

On 03/13/2023, I reviewed the incident report (IR) received on 03/03/2023. The IR states that on 03/03/2023 at 1:50 am, staff, Terri Ellis was making her rounds and checked on Resident A. Ms. Ellis found Resident A not breathing. She tested her vitals and there were none. Ms. Ellis contacted Hospice and Resident A's guardian.

On 03/13/2023, I received and reviewed Resident A's Order Summary Report. The report reflects that on 03/01/2023, Dr. Jennifer White prescribed Resident A Lorazepam 2mg/ml as needed for anxiety and agitation. On 03/01/2023, Dr. White also prescribed Resident A Morphine Sol 20mg/1ml for moderate to severe pain. The order reflected there was no prescription for Norco in the Medication Administration System, which is updated by Mercy Long Term Care Pharmacy.

On 04/10/2023, I spoke with Mrs. Lutzke who stated Ms. Decator no longer works at the facility and is no longer the appointed licensee designee. Ms. Lutzke stated Miranda Cockrell is the new licensee designee.

On 04/13/2023, I received and reviewed Resident A's Medication Administration Record (MAR) for the months of February 2023 and March 2023. The MAR

reflected that on 02/25/2023, 02/26/2023, 02/28/2023 and 03/01/2023 Resident A was administered Acetaminophen 325mg for pain. On 02/26/2023, 02/27/2023 and 03/02/2023 Resident A was administered Morphine SOL 20mg for pain. The MAR did not reflect Resident A was prescribed or administered Norco for pain.

On 04/17/2023, I completed an exit conference with Miranda Cockrell. She was informed of the investigation findings and recommendation. A corrective action plan will be submitted to licensing.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 03/02/2023, a complaint was received alleging Resident A was not administered any pain medication, specifically Norco for several days. Resident A was under the care of Hospice and passed away on 03/03/2023. Staff Angela Decator, and Bridget Lutzke both stated that on 02/24/2023, staff contacted the Hospice Nurse because Resident A began crying out in pain. Hospice place an order for Resident A to be administered Norco; however, the order was never entered in the pharmacy's system. This was not discovered until 02/27/2023. Resident A's facility records reflected a physician's order, prescribing Norco for pain. The medication administration record reflected Resident A was not administered Norco 02/24/2023 through 02/27/2023. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff did not ensure Resident A's prescription was filled so that her pain was addressed.
CONCLUSION:	**VIOLATION ESTABLISHED**

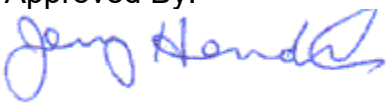
IV. RECOMMENDATION

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

04/21/2023

Megan Aukerman Date
Licensing Consultant

Approved By:



04/21/2023

Jerry Hendrick Date
Area Manager