GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2023

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

RE: License #: AL410398969
Investigation #: 2023A0350025
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) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410398969
Investigation #:	2023A0350025
Complaint Receipt Date:	06/13/2023
Investigation Initiation Date:	06/13/2023
Report Due Date:	07/13/2023
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:	05/02/2023
Expiration Date:	05/01/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Terri Ellis, DCW, smoked marijuana and slept on the job.	No
Some staff members bring their children to work.	Yes
A former staff member exchanged personal cell phone numbers with a resident and had an inappropriate relationship.	Yes
Staff sometimes serve food that is expired.	No
There was a suspicious death of a resident recently.	No

III. METHODOLOGY

06/13/2023	Special Investigation Intake 2023A0350025
06/13/2023	APS Referral
06/13/2023	Special Investigation Initiated - Letter Sent and received emails with Heather Autsema, Adult Protective Services investigator
06/15/2023	Contact - Face to Face I met Ms. Autsema at this home and we interviewed staff and residents
06/15/2023	Contact - Telephone call made I held a video phone conference with Miranda Cockrell, Licensee Designee
06/15/2023	Contact - Document Sent I sent an email to Mechelle Holt, Wellness Director
06/15/2023	Contact - Document Sent I sent an email to Ms. Autsema
06/16/2023	Contact - Document Received I received an email from Ms. Holt
06/16/2023	Contact - Document Sent I sent an email to Ms. Autsema
06/16/2023	Contact – Telephone call made I spoke with LaToya Brown, DCW

06/16/2023	Contact – Telephone call made I spoke with Tamarionna Craig, DCW
06/16/2023	Contact – Telephone call made I spoke with Dandre Harris, DCW
06/16/2023	Contact – Telephone call made I spoke with Terri Ellis, DCW
06/20/2023	Contact - Document Sent I sent an email to Ms. Cockrell
06/20/2023	Contact - Document received I received an email from Ms. Cockrell
06/21/2023	Contact - Document received I received an email from Ms. Holt
06/26/2023	Contact - Document Sent I sent an email to Ms. Cockrell
06/26/2023	Contact - Document received I received an email from Daniel Barberi, Business Development Manager, Interim HealthCare
06/26/2023	Contact - Document sent I sent an email to Sarah Choryan, Director of Healthcare Services Interim Healthcare - Hospice
06/26/2023	Contact - Document received I sent an email from Ms. Choryan
06/27/2023	Exit conference – Held with Miranda Cockrell, Licensee Designee

ALLEGATION: Terri Ellis, DCW, smoked marijuana and slept on the job.

INVESTIGATION: On 06/13/2023, through emails, I arranged to meet Heather Autsema, Adult Protective Services (APS) investigator, at this home on 06/15 at 9:30 a.m.

On 06/15/2023, I met Ms. Autsema at this home and we spoke with Mechelle Holt, Wellness Director, and Miranda Cockrell, Licensee Designee. I asked Ms. Cockrell if there is an employee working there named “Terri,”. Ms. Cockrell confirmed that Terri Ellis works at the facility. I inquired as to whether it was reported to her that Ms. Ellis smokes marijuana and/or sleeps on the job, and she told me that no one has

reported either of these things to her. Ms. Cockrell informed Ms. Autsema and me that Ms. Ellis has worked for Care Cardinal, the company that owns and operates this home, for about two years, and that she had a good work performance record. She has not been written up for anything. Ms. Cockrell also stated that Ms. Ellis was a “transitional” worker, which means she works at several different facilities, going wherever needed.

On 06/16/2023, I sent an email to Ms. Cockrell requesting the names and cell phone numbers of the third shift staff members.

On 06/16/2023, I received an email from Ms. Cockrell with the requested information.

On 06/16/2023, I called three Direct Care Workers, LaToya Brown, Tamarionna Craig, and Dandre Harris, and asked each of them if they had ever observed or heard about any coworker sleeping or smoking marijuana on the job, and they each stated that they have not.

On 06/16/2023, I called and spoke with Terri Ellis, DCW and asked her if she has ever fallen asleep or smoked marijuana of the job, and she denied doing either, adding that she doesn’t smoke at all. Ms. Ellis informed me that she has worked for this company for three years and has been doing direct care for twenty. She also stated that she has only been back to work for a few days, as she was off for seven weeks for medical reasons.

On 06/27/2023, I called and held an exit conference with Miranda Cockrell, Licensee Designee. I informed Ms. Cockrell that I was not citing a violation of this rule. She thanked me for letting her know and had no further questions.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.**
ANALYSIS:	Miranda Cockrell, Licensee Designee, and Mechelle Holt, Wellness Director, both stated that Terri Ellis, DCW, has been working for Care Cardinal for about two years and has a good work record. They also both said that no staff member or resident has informed them that Ms. Ellis slept or smoked marijuana during her shift.

	Direct Care Workers, LaToya Brown, Tamarionna Craig, and Dandre Harris, all reported that they have not observed or heard that Ms. Ellis has slept or smoked marijuana on the job. Ms. Ellis denied that she had either slept or smoked marijuana on the job, and added that she does not smoke at all. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Some staff members have brought their children to work.

INVESTIGATION: On 06/15/2023, Ms. Autsema and I interviewed Ms. Holt and Ms. Cockrell and inquired about whether any staff members have brought their children to work with them. Ms. Holt said that there were two staff members who did so within the past couple of months, but both have been terminated. She stated that one of these former staff members was informed not to bring her children to work, and she did again anyway. Ms. Holt said that no staff member or resident has reported that any current staff member has brought their children to work.

On 06/27/2023, I called and held an exit conference with Miranda Cockrell, Licensee Designee. I informed Ms. Cockrell that I was a citing violation of this rule. She thanked me for letting her know and had no further questions.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was confirmed that two former staff members had brought their children to work, and both were terminated. Staff members bringing children to work violates the rights of the residents to be treated with respect and dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: A former staff member exchanged personal cell phone numbers with a resident and had an inappropriate relationship.

INVESTIGATION: On 06/15/2023, Ms. Autsema and I interviewed Ms. Holt and Ms. Cockrell. Ms. Holt told us that Audrey Kaptien, a former employee, exchanged phone numbers with Resident A and that some of their language with each other was inappropriate, such as Resident A referring to Ms. Kaptien as “babe.” Ms. Holt stated that when confronted about this in April (2023), Ms. Kaptien quit.

On 06/15/2023, Ms. Autsema and I interviewed Resident A who confirmed that he and Ms. Kaptien exchanged phone numbers. Resident A stated that some of their exchanges were as if they were “more than friends,” but he denied that their relationship ever got physical. Resident A also denied that he and any other staff member have exchanged phone numbers or had a “more than friends” relationship.

On 06/27/2023, I called and held an exit conference with Miranda Cockrell, Licensee Designee. I informed Ms. Cockrell that I was citing a violation of this rule. Ms. Cockrell mentioned that Ms. Kaptien was terminated before she started working there. I stated that, regardless of that fact, it was still a rule violation.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Audrey Kaptien, a former employee, exchanged phone numbers with Resident A when she was still working there and some of their language between each other was inappropriate. Resident A described their relationship as being “more than friends.” My findings support that this rule has been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff sometimes serve food that is expired.

INVESTIGATION: On 06/15/2023, Ms. Autsema and I interviewed Ms. Holt and Ms. Cockrell and asked about the freshness of the food being served there. Ms. Holt told us that food is delivered every Monday and Wednesday from Aldi’s and Gordon’s Food Service and that all food stock is rotated on a regular basis so that the items with the soonest expiration date are put in front. Ms. Cockrell went to the freezer and pulled out a couple of items and showed me their expiration dates. I observed that a

package of fish was dated 09/21/2024 and the package of hamburger was dated 03/28/2024. I then asked her to show me some canned food and observed that the first can she pulled off was dated 05/20/2025 and the second was dated 01/31/2025.

On 06/27/2023, I called and held an exit conference with Miranda Cockrell, Licensee Designee. I informed Ms. Cockrell that I was not citing a violation of this rule. She thanked me for letting her know and had no further questions.

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:	Fresh, frozen, and canned food items are delivered to this home on Mondays and Wednesdays of each week. I observed that the frozen food items at the front of the freezer were not expired; and that canned items to be used next were also not expired.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: There was a suspicious death of a resident recently.

INVESTIGATION: On 06/15/2023, Ms. Autsema and I interviewed Ms. Holt and Ms. Cockrell and inquired about whether any resident had died within the past few months. We were informed that Resident D passed away in March (2023), and that she had been on hospice. I asked for a copy of the Incident Report regarding Resident D's death, and Ms. Cockrell provided Ms. Autsema and me a copy. The Incident Report states, *'During routine rounds, observed (Resident D) not moving. Took vitals to ensure proper steps. Called hospice, nurse, texted HM (Home Manager) contact daughter [sic].'*

On 06/20/2023, I sent an email to Ms. Cockrell, requesting the name and phone number of the hospice nurse who attended to Resident D on 03/02/2023.

On 06/21/2023, I received an email from Ms. Holt stating that Resident D died at 98 years old of natural causes.

On 06/26/2023, I sent an email to Sarah Choryan, Director of Healthcare Services Interim Healthcare – Hospice, requesting the name and phone number of the hospice nurse who attended to Resident D on 03/02/2023.

On 06/26/2023, I received an email from Ms. Choryan, who stated, “The nurse who pronounced death on March 2nd was Pam Burns, RN. She has since retired and we do not have contact information for her.”

On 06/27/2023, I called and held an exit conference with Miranda Cockrell, Licensee Designee. I informed Ms. Cockrell that I was not citing a violation of this rule. She thanked me for letting her know and had no further questions.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Resident D passed away on March 3, 2023 while on hospice. She was 98 and died of natural causes. No one from Interim Healthcare, including the hospice nurse who tended to Resident D upon her death, reported any suspicions regarding this death. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home’s license remains unchanged, and that this special investigation be closed.

June 27, 2023

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Ian Tschirhart Date
Licensing Consultant

Approved By:

June 28, 2023

Jerry Hendrick
Area Manager

Date