GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 30, 2023

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

RE: License #:	AL410384527
Investigation #:	2024A0356006
	Alger Heights - North

Dear Ms. 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410384527
Investigation #:	2024A0356006
Complaint Receipt Date:	10/03/2023
Investigation Initiation Date:	10/03/2023
Report Due Date:	12/02/2023
Licensee Name:	CSM Alger Heights, LLC
Licensee Address:	1019 28th St. Grand Rapids, MI 49507
Licensee Telephone #:	(616) 258-0268
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
Name of Facility:	Alger Heights - North
Facility Address:	1015 28th St. SE Grand Rapids, MI 49548
Facility Telephone #:	(616) 229-0427
Original Issuance Date:	10/25/2016
License Status:	REGULAR
Effective Date:	04/25/2023
Expiration Date:	04/24/2025
Capacity:	17
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications are not being administered as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/03/2023	Special Investigation Intake 2024A0356006
10/03/2023	Special Investigation Initiated - Telephone Kristin Campbell, Area Agency on Aging. Caseworker.
10/03/2023	APS Referral Mareeta Bracken, APS, Kent County.
10/13/2023	Contact - Telephone call made. Relative #1.
10/19/2023	Inspection Completed On-site
10/19/2023	Contact - Face to Face Resident A, Cheslea Lindsey, Melanie Chelette, staff.
10/19/2023	Contact - Face to Face Mary Free Bed, Occupational therapist, Heidi Rechenberg.
10/19/2023	Contact - Document Received MAR for Resident A.
10/23/2023	Contact - Telephone call made. Kristin Campbell, AAAWM, case manager, Mareeta Bracken, Kent Co. DHHS APS worker.
10/24/2023	Contact - Document Received Dr. Robert Coleman, neurologist information per Kristin Campbell.
10/27/2023	Contact - Telephone call made. Michael Makki, Pharmacy Manager, Pharmascript.
10/27/2023	Contact - Document Received Pharmascript document.

10/27/2023	Contact - Telephone call made. Chelsea Lindsey, manager.
11/14/2023	Contact - Telephone call made. APS, Mareeta Bracken.
11/30/2023	Exit Conference-Marcia Curtiss, Licensee Designee.

ALLEGATION: Resident A's medications are not being administered as prescribed.

INVESTIGATION: On 10/03/2023, I received a BCAL (Bureau of Child and Adult Licensing) online complaint. The complainant reported Resident A's medication administration is incorrect. Resident A has Parkinson disease, and his morning medication is being administered at random times. The complainant reported that Resident A requires his Parkinson's medications to be administered at specific times and the facility is not giving the medication to him at the correct times, which causes tremors to flare up and makes him feel sick. The complainant reported that Relative #1 attempted to contact staff at the facility to discuss this concern and she was hung up on.

On 10/03/2023, I interviewed Kristin Campbell, Area Agency on Aging case manager, via telephone. Ms. Campbell stated Resident A is on Parkinson medications and while the evening medications seem to be administered at the correct time, the morning and afternoon medications are all spread out and given at differing times that are not correct. Ms. Campbell stated Relative #1 expressed concerns about the Parkinson medications and the staff not administering them at the correct times because it is important for this medication to be given specifically as directed by the physician.

On 10/13/2023, I interviewed Relative #1 via telephone. Relative #1 stated staff at the facility are "clumping the (Parkinson) meds together" and giving them to Resident A at the wrong times. Relative #1 stated they are administering Resident A's Carbidopa/Levodopa at 1:00p.m., 2:00p.m., and 3:00p.m. when the medication should be administered at noon, 2:00p.m., 4:00p.m., & 6:00p.m. Relative #1 stated the medication should be administered 6 times daily and while he may be getting the meds 6 times daily, it is not at the correct times which causes unsteadiness and tremors. Relative #1 stated Resident A's other medications are administered as prescribed.

On 10/19/2023, I conducted an unannounced inspection at the facility and interviewed Chelsea Lindsey, Executive Director and we reviewed Resident A's medications Carbidopa/Levodopa. The medications come in card style pop out meds from Pharmascript of MI pharmacy. The medications have a separate card for each 'Morning, noon and afternoon, Carbidopa/Levodopa 25/100mg, take ½ tablet by

mouth four times daily.' Another card of medications documented, 'Bedtime 50-200mg, 1 tablet by mouth at bedtime.'

Ms. Lindsey and I reviewed the MARs (medication administration record) for the month of October 2023. Resident A's Carbidopa/Levodopa 25/100mg, take ½ tablet by mouth four times daily has times documented for administration of the medication on the MAR at 4:00a.m., 8:00a.m., 10:00a.m., 12: 00p.m, 2:00p.m., 4:00p.m., 8:00p.m. and 10:00p.m. Staff signatures for this medication, indicating that the medication was administered at these times is sporadic and not complete for the entire month to date. Ms. Lindsey stated she does not know how this many times for the administration of Carbidopa/Levodopa got on the MAR and the only time he gets this medication, is as directed on the labels of the medications, in the morning, at noon, afternoon and at bedtime. Resident A's Carbidopa/Levodopa 50-200mg is on the MAR to be administered at 7:00p.m. and is signed from 10/03/2023 to10/18/2023. After a review of this MAR, it does not appear as though Resident A received this medication much at all to date except for the evening tablet. I asked Ms. Lindsey about staff answering the telephone at the facility and she stated staff answer the telephones in the facility but sometimes residents will also answer the phones and it is possible that a resident hung up the phone on the caller but she will address it with staff.

On 10/19/2023, I interviewed Direct Care Worker (DCW) Melanie Chelette. Ms. Chelette stated she administers Resident A's Carbidopa/Levodopa medication during her shift, in the morning, noon and afternoon as prescribed. Ms. Chelette stated she has an hour of time before the administration time and an hour after administration time to pass the medication. Ms. Chelette stated she administers the medication at 8:00a.m., 10:00a.m., 2:00p.m. and 7:00p.m. but usually the 7:00p.m. administration occurs when the 8:00p.m. medications are administered since they have an hour before or an hour after to administer the resident medications.

On 10/19/203, I went to interview Resident A in his room at the facility. There was an Occupational Therapist in the room from Mary Free Bed, Heidi Richenberg. Ms. Richenberg stated as a "rule of thumb," Resident A's carbidopa/levodopa should be administered at the same time each day as it reduces the side effects Resident A would have from the Parkinsons. Ms. Richenberg stated given at different times, it can lessen the effectiveness the medication has on Resident A's symptoms, and he can experience increased stiffness among other side effects.

I interviewed Resident A and he stated he knows one of his Parkinson's medications was cut down to ½ a tablet, that he takes one at 8:00a.m. and 10:00a.m. but he "leaves it up to staff" to administer his medications when he is supposed to get them. He does not know if he gets them at the correct time or not. Resident A stated his neurologist, Dr. Coleman told him that he must take the medications at the same time each day. Resident A reported that he gets a "racing" feeling often but he is not sure if that is from too much of the medication or not at the right time, he leaves all

that up to staff. Ms. Chelette administered Resident A's Carbidopa/Levodopa medication at 2:30p.m. while I was present.

On 10/24/2023, Ms. Campbell called me and informed me that she spoke to Rebecca at Dr. Robert Coleman's office and Rebecca informed her that "(Resident A's) medication should be taken at the following times: 25-100mg dosing at 8am, 11am, 2pm and 5pm. 50-100 ER at 8pm. Per Rebecca dosing should be as close as possible to these times, and preferably at these times. If unable, 1/2-hour leeway given. Rebecca reports orders are very specific and sent to pharmacy with these specific dose times."

On 10/26/2023, I interviewed Mareeta Bracken, APS (Adult Protective Services) worker, Kent County DHHS (Department of Health and Human Services). Ms. Bracken stated she is investigating this allegation and interviewed DCW Tionna Lyons. Ms. Bracken stated Ms. Lyons reported that Resident A's Carbidopa/levodopa is administered at 8:00a.m.,12:00p.m., 2:00p.m. and 7:00p.m. Ms. Lyons stated if staff are not able to administer the medication on the hour, they have ½ hour leeway time to get the medication to Resident A.

On 10/27/2023, I interviewed Michael Makki, Pharmacy Manager at Pharmascript of Grand Rapids. Mr. Makki stated on 09/30/2023, from an order, they input the hours of administration of Resident A's Carbidopa/Levodopa medication as 8:00a.m.,12:00p.m.,4:00p.m. and 8:00p.m. On 10/04/2023, Ms. Lyons (DCW) entered the system at 10:35a.m. and changed the administration times to 2:00a.m.,10:00a.m.,4:00a.m. and 12:00p.m., then on the same date, 10/04/2023 at 11:39a.m., she is logged in and added the times of 2:00p.m.,10:00p.m. and 4:00p.m. In addition, Ms. Lyons added Andrea Sylvester as the prescribing doctor. On 10/09/2023 at 8:16a.m., Ms. Lyons added times for administration of the same medication at 8: 00a.m and 10:00a.m. and then again on 10/09/2023, at 8:17a.m., Ms. Lyons added 4:00a.m. and 2:00p.m. for administration of Resident A's Carbidopa/Levodopa. Mr. Makki stated he was called by Ms. Lindsey on 10/20/2023, and he changed the incorrect times on the system so they would show on the MAR again for the correct times of 8:00a.m.,12:00p.m., 4:00p.m. and 8: 00p.m based on the doctor's order they had at that time. I reviewed the Quick MAR 'edit history for carbidopa/levodopa 25/100' for Resident A for the end of September and October 2023 with Mr. Makki and was able to see the changes made to the MAR by Ms. Lyons.

On 10/27/2023, I called Ms. Lindsey and informed her of why the MAR had so many times for the administration of Resident a's Parkinson's medications. Ms. Lindsey stated the day after my inspection at the facility, on 10/20/2023, she contacted the pharmacy and had the times changed back to 8a.m.,12p.m.,4p.m. and 8p.m. and then had a meeting with Dr. Coleman. After the meeting, Resident A's medication administration times were set as ½ tab, 25-100mg at 8:00a.m.,11:00a.m., 2:00P.M. and 5:00p.m. and Resident A's medication full tab, 50-200 mg is to be administered at 8:00p.m. Ms. Lindsey stated the MAR is now updated and accurate. Ms. Lindsey

called Jeannine Hayes, facility nurse and had her restrict staffs' ability to change the times of the administration of resident medications on the MAR.

On 11/14/2023, Ms. Bracken sent a copy of the physician's orders dated 11/01/2023. The orders document the administration times for Resident A's carbidopa/levodopa medication as one tab, 20/100 at 8:00a.m.,11:00a.m., 2:00p.m., 5:00p.m. and one tab, 50/200 at 8:00p.m. Ms. Bracken stated her investigation remains open at this time.

On 11/30/2023, I conducted an exit conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she will review the report and submit an acceptable corrective action plan.

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 {333.1101 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:	The complainant reported that Resident A's Parkinson's medications are not being administered at the correct times. Ms. Campbell stated the evening medications seem to be administered at the correct time, but the morning and afternoon medications are not correct. Relative #1 concurred with Ms. Campbell's report. The labels on the medication card instructions documented the Carbidopa/Levodopa 25/100 administration to be morning, noon, and afternoon, the 50-200 administration to be administered at bedtime. The October 2023 MAR documented medication administration times for Resident A's Carbidopa/Levodopa at 4:00a.m., 8:00a.m., 10:00a.m., 12: 00p.m, 2:00p.m., 4:00p.m., 8:00p.m. and 10:00p.m.

	Staff signatures on the MAR indicate the medication was administered sporadically and not complete for the entire month of October 2023 to date. Ms. Chelette stated she administers Resident A's medication as prescribed, at 8:00a.m., 10:00a.m., 2:00p.m. and 7:00p.m. Ms. Richenberg stated Resident A's carbidopa/levodopa should be administered at the same time each day. Dr. Robert Coleman's office reported Resident A's medication should be taken at 8am,11am, 2pm, 5pm and 8pm. Ms. Bracken stated Ms. Lyons reported that Resident A's Carbidopa/levodopa is administered at 8:00a.m., 12:00p.m.,2:00p.m. and 7:00p.m. Mr. Makki stated staff Tiona Lyons entered the MARs system and changed the time of the administration of Resident A's Carbidopa/Levodopa several times on different dates. Ms. Lindsey acknowledged there was an issue with staff changing the times of Resident A's medications on the MAR. Dr. Coleman's orders document the administration times for Resident A's carbidopa/levodopa medication as 8:00a.m.,11:00a.m., 2:00p.m., 5:00p.m. and 8:00p.m. Based on investigative findings, there is a preponderance of evidence to show that Resident A's medication Carbidopa/Levodopa was not being administered as prescribed and therefore a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 10/27/2023, I interviewed Mr. Makki, and he reported that Ms. Lyons went into the Quick MAR system three times on 10/04/2023, and twice on 10/9 and made changes to the times of the administration of Resident A's medication Carbidopa/Levodopa 25/100 adding double the number of administrations as prescribed. The MAR showed Resident A requires administration of the medication eight times a day when Resident A is prescribed the medication four times daily. I reviewed the Quick Mar edit history with Mr. Makki and was able to see where Ms. Lyons made changes to the MAR.

On 11/30/2023, I conducted an exit conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she will review the report and submit an acceptable corrective action plan.

ADDITIONAL FINDING	
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: (e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	Based on my investigative findings, there is evidence to show that on 10/04/2023 and 10/09/2023, Ms. Lyons entered the Quick MAR edit history and made changes to the times Resident A's carbidopa/levodopa was to be administered. The MARs showed that Resident A was to receive the medication 8 times a day rather than the 4 times a day prescribed. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 10/19/2023, I reviewed Resident A's MAR for Oct 2023. The MAR is signed from 10/03/2023-10/18/2023 for the 7:00p.m. administration of Resident A's carbidopa/levodopa 50/200mg, take one tablet by mouth daily at bedtime. There are no staff signatures for 10/01/2023-10/02/2023 showing the medication was administered as prescribed.

I reviewed Resident A's MAR for October 2023 for the medication carbidopa/levodopa 25/100mg, take ½ tablet by mouth four times daily, however, the MAR has 8 times listed on the MAR as times when staff were to administer the medication, (which is erroneous) yet over the 8 times, there are 92 spots that staff were required to sign when the medication was administered and did not do so.

On 11/30/2023, I conducted an exit conference with Licensee Designee, Marcia Curtiss via telephone. Ms. Curtiss stated she will review the report and submit an acceptable corrective action plan.

ADDITIONAL FINDING	
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 the following provisions: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on my investigative findings, there is evidence to show that on the October 2023 MAR, the medication, carbidopa/levodopa, was documented to be administered 8 times daily, which was in error however, 94 of the spaces that staff were required to document on the MAR were not signed by staff. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/30/2023

Elizabeth Elliott Date
Licensing Consultant

Approved By:

11/30/2023

Jerry Hendrick Date
Area Manager