GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 30, 2024

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

RE: License #: AL410398969
Investigation #: 2024A0583035
Willow Creek - West

Dear Mrs. Curtiss:

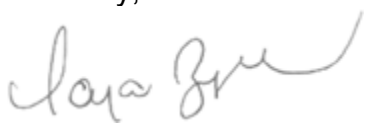
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410398969
Investigation #:	2024A0583035
Complaint Receipt Date:	05/17/2024
Investigation Initiation Date:	05/17/2024
Report Due Date:	06/16/2024
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:	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, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff yell at Resident A	No
Facility staff failed to obtain needed medical care for Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/17/2024	Special Investigation Intake 2024A0583035
05/17/2024	APS Referral
05/17/2024	Special Investigation Initiated - Letter
05/20/2024	Inspection Completed On-site
05/24/2024	Inspection Completed On-site
05/29/2024	Exit Conference Licensee Designee Marcia Curtiss

ALLEGATION: Facility staff yell at Resident A.

INVESTIGATION: On 05/17/2024 I received complaint allegations from Adult Protective Services (APS) via the BCAL online reporting system. The complaint stated that Resident A resides in a group home, has a guardian, and has type two diabetes. The complaint stated that Resident A is diagnosed with a developmental/intellectual disability. The complaint alleged that facility staff yell at Resident A.

On 05/17/2024 I received an email from APS staff Bryan Kahler. Mr. Kahler stated that the complaint is currently assigned to APS staff Marcus McLemore to investigate.

On 05/20/2024 I completed an unannounced onsite investigation at the facility and privately interviewed staff Ericka Zoerhof and Resident A.

Resident A stated that approximately one month ago he requested his “stomach medication” which he identified to be a PRN “for diarrhea” from staff Tayshaunna Poole. Resident A stated that Ms. Poole’s head was down on the table at the time he requested said medication. Resident A stated that Ms. Poole ignored his medication request and Resident A asked Resident B if Ms. Poole was asleep or ignoring him? Resident A stated that Ms. Poole overheard his conversation with Resident B and stated, “I’m not ignoring you and I am not sleeping”. Resident A stated that Ms. Poole was upset as evidenced by her loud voice tone. Resident A

stated that he walked into his bedroom and Ms. Poole followed him into his bedroom and shut the door. Resident A stated that Ms. Poole yelled at him and stated, “you’re going to get me fired, well I’m going to get you evicted”. Resident A stated that no one else was present in his bedroom and Ms. Poole left shortly afterwards. Resident A stated that Ms. Poole yelled so loud in his bedroom that he suspected that staff Aniberci Abreu may have overheard as she was the only other staff present.

Staff Ericka Zoerhof stated that staff Tayshaunna Poole was recently fired due to displaying a “hot head” towards other staff members. Ms. Zoerhoff stated that she became aware of Resident A’s allegations after Ms. Poole was fired and therefore did not investigate the matter.

On 05/23/2024 I interviewed staff Aniberci Abreu via telephone. Ms. Abreu spoke limited English. Ms. Abreu stated that she never observed Staff Tayshanna Poole verbally abuse Resident A.

On 05/23/2024 I interviewed Resident B via telephone. Resident B stated that she did observe staff Tayshaunna Poole with her head down on the table when Resident A requested a medication but did not observe Ms. Poole yell at Resident A.

On 05/29/2024 I completed an Exit Conference with Licensee Designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had nothing to add to the Special Investigation report until after she has read the report.

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:	Resident A stated that approximately one month ago he requested his stomach medication from staff Tayshaunna Poole. Resident A stated that Ms. Poole was upset as evidenced by her loud voice tone. Resident A stated that he walked into his bedroom and Ms. Poole followed him into his bedroom, shut the door, and yelled “you’re going to get me fire, well I’m going to get you evicted”. Staff Aniberci Abreu and Resident B both reported that they did not observe Ms. Poole verbally mistreat Resident A. Insufficient evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff failed to obtain needed medical care for Resident A.

INVESTIGATION: On 05/17/2024 I received complaint allegations from APS via the BCAL online reporting system. The complaint alleged that Resident A has been having tooth pain for the past three days and facility staff failed to obtain medical care. The complaint stated that there is also a little bit of blood around his tooth, and it is loose and the pain is radiating to his jaw.

On 05/20/2024 I spoke with APS staff Marcus McLemore via telephone. Mr. McLemore confirmed that he referred the allegations to LARA for investigation and is currently investigating the matter. Mr. McLemore stated that Resident A's public guardian Kristina Bagley has recently scheduled a medical appointment for Resident A's tooth. Mr. McLemore reported that he completed an onsite investigation at the facility and spoke with staff Nita Hewlett. Mr. McLemore stated that Ms. Hewlett didn't seem to understand that the facility staff could seek treatment for Resident A's infected tooth at an urgent care facility or emergency department.

On 05/20/2024 I completed an unannounced onsite investigation at the facility and privately interviewed staff Ericka Zoerhof, staff Nita Hewlett, staff Shanice Wilson, and Resident A.

Staff Ericka Zoerhoff stated that Resident A was diagnosed with an infected tooth by Nurse Practitioner Andrea Sylvester on 05/17/2024 and was prescribed Clindamycin 300 MG three times daily.

Staff Nita Hewlett stated that on the evening of 05/15/2024 she was not working at the facility, but she received a telephone call from staff Shanice Wilson who reported that Resident A had heavy pain radiating from his tooth. Ms. Hewlett stated that Ms. Wilson reported that Resident A did not have a "PRN" for pain relief. Ms. Hewlett stated that she directed Ms. Wilson to contact "Home MD" and Resident A's guardian to request guidance. Ms. Hewlett stated that Resident A's guardian, Kristina Bagley did not respond to facility staff telephone calls and Home MD informed Ms. Wilson to contact Resident A's guardian to make a medical appointment. Ms. Hewlett stated that Nurse Practitioner Andrea Sylvester arrived at the facility on her regularly scheduled facility appointment on 05/17/2024 and observed that Resident A's tooth was infected and required an antibiotic for treatment.

Staff Shanice Wilson stated that she worked at the facility on the evening of 05/15/2024. Ms. Wilson stated that Resident A complained of tooth pain and Ms. Wilson visually observed Resident A's tooth appeared "rotten". Ms. Wilson stated that Resident A's Medication Administration Record did not contain a "PRN" for pain

management. Ms. Wilson stated that she telephoned staff Nita Hewlett around midnight and requested guidance. Ms. Wilson stated that Ms. Hewlett directed Ms. Wilson to contact Home MD for medical advice. Ms. Hewlett stated that she contacted Home MD on the morning of 05/16/2024 and was directed to contact Resident A's guardian to schedule a dental appointment and seek medical treatment at the emergency department if Resident A's pain persisted. Ms. Wilson stated that she left the facility on 05/16/2024 at approximately 11:00 AM and during shift change directed staff Benjila Green to contact Resident A's guardian regarding his continued tooth pain. Ms. Wilson stated that she did not make attempts to contact Resident A's guardian regarding his tooth pain.

Resident A stated that on the evening of 05/15/2024 he reported to staff Shanice Wilson that his tooth was painful. Resident A stated that Ms. Wilson said that she could not provide Resident A with pain medication because Resident A did not have a PRN. Resident A stated that he did not receive any pain medication and did not see a medical provider until 05/17/2024 when Nurse Practitioner Andrea Sylvester visited the facility for her regularly scheduled facility appointment. Resident A stated that on 05/17/2024 Ms. Sylvester diagnosed Resident A with an infected tooth and prescribed an antibiotic and PRN for pain management.

On 05/21/2024 I received an email from staff Ericka Zoerhof which I observed to contain Resident A's Medication Administration Record from 05/01/2024 to current. The document indicated that Resident A was prescribed Clindamycin 300 MG three times daily on 05/17/2024 by Nurse Practitioner Andrea Sylvester and Ms. Sylvester refilled Resident A's PRN Tylenol 325 MG on 05/17/2024. Documentation indicated that Resident A has been receiving Clindamycin 300 MG as prescribed.

On 05/23/2024 I spoke with Kristina Bagley via telephone. Ms. Bagley stated that she is Resident A's guardian. Ms. Bagley stated that she was not alerted by facility staff of Resident A's infected tooth until 05/21/2024 after Resident A had been evaluated and treated by Nurse Practitioner Andrea Sylvester. Ms. Bagley stated that she has found communication from facility staff as lacking and the facility staff are "very hard to get ahold of". Ms. Bagley stated that facility staff do not regularly call her back and often call her on their personal cell phones.

On 05/28/2024 I interviewed Nurse Practitioner Andrea Sylvester via telephone. Ms. Sylvester stated that she observed Resident A at the facility on 05/17/2024 for a routinely scheduled appointment and diagnosed Resident A with a tooth infection. Ms. Sylvester stated that she prescribed an antibiotic and refilled Resident A's PRN Tylenol 325 MG for pain. Ms. Sylvester stated that Resident A's tooth infection required medical attention prior to her 05/17/2024 evaluation.

On 05/29/2024 I received and reviewed an email from Nurse Practitioner Andrea Sylvester. Ms. Sylvester stated that her medical practice received no communication from the facility relating to Resident A's tooth pain prior to her regularly scheduled onsite medical visit on 05/17/2024.

On 05/29/2024 I completed an Exit Conference with Licensee Designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had nothing to add to the Special Investigation report until after she has read the report. Ms. Curtiss stated that she would submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Staff Shanice Wilson stated that she worked at the facility on the evening of 05/15/2024. Ms. Wilson stated that Resident A complained of tooth pain and Ms. Wilson visually observed Resident A's tooth appeared "rotten". Resident A stated that on the evening of 05/15/2024 he reported to staff Shanice Wilson that his tooth was painful. Resident A stated that he did not receive any pain medication and did not see a medical provider until 05/17/2024 when Nurse Practitioner Andrea Sylvester visited the facility for her regularly scheduled facility appointment. Resident A stated that on 05/17/2024 Ms. Sylvester diagnosed Resident A with an infected tooth and was prescribed an antibiotic and PRN for pain management. Resident A's public guardian Kristina Bagley stated that she was not alerted by facility staff of Resident A's infected tooth until 05/21/2024 after which Resident A had been evaluated and treated by Nurse Practitioner Andrea Sylvester. Nurse Practitioner Andrea Sylvester stated that she observed Resident A at the facility on 05/17/2024 for a routinely scheduled appointment and diagnosed Resident A with a tooth infection. Ms. Sylvester stated that she prescribed an antibiotic and refilled Resident A's PRN Tylenol 325 MG for pain. Ms. Sylvester stated that Resident A's tooth infection required medical attention prior to her 05/17/2024 evaluation. A preponderance of evidence was discovered to substantiate violation of the applicable rule; facility staff did not obtain needed care immediately for Resident A's infected tooth.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Facility staff do not administer Resident A's medications as prescribed.

INVESTIGATION: On 05/21/2024 I received an email from staff Ericka Zoerhof which contained Resident A's Medication Administration Record from 05/01/2024 to current. This document indicated that Resident A is prescribed Trulicity injection .75/.5 once weekly and indicated that on 05/16/2024 Resident A was not administered Trulicity .75/.5 due to "waiting on med from pharmacy".

On 05/24/2024 I completed an announced onsite investigation at the facility and interviewed staff Ericka Zoerhof. Ms. Zoerhof confirmed that Resident A did not receive his prescribed Trulicity .75/.5 due to "waiting on med from pharmacy".

On 05/28/2024 I completed a LARA file review and confirmed that on 09/25/2023 the facility was found to have violated R 400.15312 (2) (Special Investigation 2023A0340040) because of residents not receiving their prescribed medications. A Corrective Action Plan dated 10/11/2023 was approved.

On 05/29/2024 I completed an Exit Conference with Licensee Designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had nothing to add to the Special Investigation report until after she has read the report. Ms. Curtiss stated that she would submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's Medication Administration Record from 05/01/2024 to current indicated that Resident A is prescribed Trulicity injection .75/.5 once weekly. This document indicated that on 05/16/2024 Resident A was not administered Trulicity .75/.5 due to "waiting on med from pharmacy". A preponderance of evidence was discovered to substantiate repeat violation of the applicable rule. Facility staff did not administer Resident A's Trulicity pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED** (Repeat violation from 2023A0340040)

ADDITIONAL FINDINGS: Facility staff failed to contact the appropriate health care professional after a medication error and resident refusals.

INVESTIGATION: On 05/21/2024 I received an email from staff Ericka Zoerhof which contained Resident A's Medication Administration Record from 05/01/2024 to current. This document indicated that Resident A is prescribed Trulicity injection .75/.5 once weekly and indicated that on 05/16/2024 Resident A was not administered Trulicity .75/.5 due to "waiting on med from pharmacy". The document also indicated that Resident A is prescribed Glargin YFGN injection once daily and Resident A refused this medication from 05/01/2024 to 05/20/2024.

On 05/24/2024 I completed an announced onsite investigation at the facility and interviewed staff Ericka Zoerhof. Ms. Zoerhof confirmed that on 05/16/2024 Resident A did not receive his prescribed Trulicity .75/.5 due to "waiting on med from pharmacy" and no medical professional was contacted. Ms. Zoerhof confirmed that Resident A refused his prescribed daily Glargin YFGN injection from 05/01/2024 until 05/20/2024 and no medical professional was contacted.

On 05/28/2024 I completed a LARA file review and confirmed that on 09/25/2023 the facility was found to have violated R 400.15312 (4) (f) (Special Investigation AL410398969) because of residents not receiving their prescribed medications and facility staff failing to contact the appropriate health care professional. A Corrective Action Plan dated 10/11/2023 was approved.

On 05/29/2024 I completed an Exit Conference with Licensee Designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had nothing to add to the Special Investigation report until after she has read the report. Ms. Curtiss stated that she would submit a Corrective Action Plan.

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: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Staff Ericka Zoerhof confirmed that on 05/16/2024 Resident A did not receive his prescribed Trulicity .75/.5 due to "waiting on med from pharmacy" and no medical professional was contacted. Ms. Zoerhof confirmed that Resident A refused his prescribed daily Glargin YFGN injection from 05/01/2024 to 05/20/2024 and no medical professional was contacted.

	A preponderance of evidence was discovered to substantiate a repeat violation of the applicable rule. Facility staff did not contact the appropriate health care professional after Resident A refused his prescribed Glargin YFGN the duration of the month of May 2024 and after not receiving his prescribed Trulicity on 05/16/2024.
CONCLUSION:	**VIOLATION ESTABLISHED** **(Repeat violation from** 2023A0340040**)**

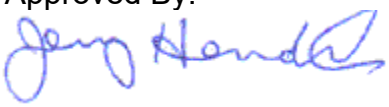
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

05/29/2024

Toya Zylstra Date
Licensing Consultant

Approved By:



05/30/2024

Jerry Hendrick Date
Area Manager