GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 07, 2024

Mechelle Genigeski
CSM Alger Heights, LLC
1019 28th St.
Grand Rapids, MI 49507

RE: License #: AL410398969
Investigation #: 2024A0467041
Willow Creek - West

Dear Mrs. Genigeski:

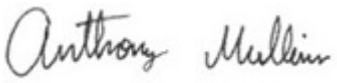
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410398969
Investigation #:	2024A0467041
Complaint Receipt Date:	06/12/2024
Investigation Initiation Date:	06/13/2024
Report Due Date:	08/11/2024
Licensee Name:	CSM Alger Heights, LLC
Licensee Address:	1019 28th St. Grand Rapids, MI 49507
Licensee Telephone #:	(616) 258-0268
Administrator:	Mechelle Genigeski
Licensee Designee:	Mechelle Genigeski
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?
Resident A was not provided with ice on 6/12/24 at 4:00 pm when requested.	No
Resident A is not receiving his 8:00 pm insulin as prescribed.	No
Additional finding	Yes

III. METHODOLOGY

06/12/2024	Special Investigation Intake 2024A0467041
06/13/2024	Special Investigation Initiated - Telephone
06/13/2024	Inspection Completed On-site
06/13/2024	Contact – Telephone call made to Vontrese Sanders
06/13/2024	Contact – Telephone call made to Benjila Green
08/06/2024	Exit conference with licensee designee, Mechelle Genigeski
08/07/2024	APS Referral

ALLEGATION: Resident A was not provided with ice on 6/12/24 at 4:00 pm when requested.

INVESTIGATION: On 6/13/24, I received a BCAL online complaint stating that Resident A asked for ice at 4:00 pm for his water and orange juice on 6/12/24 and he was told no by an African American female staff member. As a result of the staff member saying no, Resident A reportedly drank warm apple juice and water. The complainant was concerned as the temperature was approximately 88 degrees on the day in question. The complaint also alleged that Resident A is not receiving his nighttime snack.

On 6/13/23, I spoke to the complainant via phone, and she confirmed the allegation. The complainant stated that she was on the phone with Resident A when the staff member told him that he could not have any ice due to the freezer being locked in the pantry. The complainant stated that sometimes, Resident A does get things mixed up, but she knows this situation is different due to hearing the conversation herself. In addition to this, the complainant stated that Resident A was told that after

dinner, he will not be given anything else, including, ice, food, or snacks. The complainant stated that Resident A finally received his scheduled 8:00 pm diabetic snack after 11:00 pm yesterday, which was a peanut butter and jelly sandwich.

On 6/13/24, I made an unannounced onsite investigation at the facility. Upon arrival, I spoke to staff Ericka Zoerhof. Present in the room with her was licensee designee, Mechelle Genigeski. Mrs. Zoerhof stated that Resident A's guardian was communicating via text message about him not receiving a snack and ice yesterday. Mrs. Zoerhof stated that licensee designee, Mechelle Genigeski filled the fruit basket around 2:00 pm yesterday, which was readily available for all residents throughout the day. Mrs. Zoerhof stated that Resident A gets a snack whenever he wants. Mrs. Zoerhof denied any knowledge of a staff member telling Resident A 'no' to receiving ice or anything else that he has requested. Mrs. Zoerhof stated that the refrigerator is accessible 24/7 for staff and residents. I observed the refrigerator in the kitchen to be free from any locks. I also observed a bucket of ice in the refrigerator while onsite. However, there is a lock on the pantry, which is where the freezer is located. Mrs. Zoerhof stated that the pantry is only locked at night after the cook leaves. Despite the pantry being locked and staff not having access to the freezer at night, Mrs. Zoerhof shared that there is always a bucket of ice in the refrigerator as I saw during this visit. Mrs. Zoerhof stated that the pantry is locked to keep staff out of the pantry as opposed to residents. Mrs. Zoerhof confirmed that Resident A is diabetic. However, she denied that he is scheduled to receive a snack at a certain time daily. Resident A's assessment plan was reviewed, and it does not list any special diets or requirements regarding food for him. Mrs. Zoerhof provided contact information for the staff that were working yesterday, which was Ani Abreu and Vontrese Sanders.

After speaking to Mrs. Zoerhof, introductions were made with Resident A and he agreed to discuss the allegation. Resident A stated that he has resided at the facility for a couple of months. Resident A stated that his guardian has encouraged him to speak up when necessary to address any issues or concerns that may arise. Resident A was asked to share what occurred yesterday when he asked for ice. Resident A stated that staff member Benjila Green told him "no" when he asked for ice yesterday for his water and orange juice. Resident A stated that the ice is in the freezer locked away in the pantry and no one can access it afterhours. Resident A stated that he was also told no to receiving a snack due to the pantry door being locked. Resident A stated that sometime after 11:00 pm, he finally received a sandwich although he originally asked for it at 7:00 pm.

On 6/13/24, I spoke to AFC staff member, Ani Abreu while onsite. Ms. Abreu stated that she has worked at the facility for approximately 6 months. Ms. Abreu confirmed that she worked yesterday from 8:00 am to 5:00 pm. Ms. Abreu stated that Resident A asks for ice all the time "and I give it to him." Ms. Abreu stated that Resident A often asks for milk and peanut butter, which she always honors. Ms. Abreu denied any knowledge of any of her peers telling Resident A no to receiving ice or a snack when he's asked. Ms. Abreu stated that Resident A and other residents can have whatever they want, whenever they ask. I observed snacks on the kitchen counter,

including bread, peanut butter, chips, popcorn, and a full fruit tray with apples, oranges, and bananas. Ms. Abreu stated that she informs Resident A daily when meals are ready, and he always comes to eat. Ms. Abreu stated that Resident A and all other residents are receiving appropriate care at the facility and their needs are being met.

On 6/13/24, I spoke to staff member, Vontrese Sanders via phone. Ms. Sanders confirmed that she worked yesterday from 7:00 am to 7:00 pm. Ms. Sanders denied Resident A asking her for ice or a snack anytime yesterday. Ms. Sanders stated that she fed all resident's dinner yesterday at 5:00 pm. After dinner, Ms. Sanders stated that Resident A went to his room and never asked her for anything else, despite checking on him. Ms. Sanders confirmed that the pantry is locked, which is where the freezer is located. Ms. Sanders stated that she is unsure why the pantry is locked. Despite this, Ms. Sanders confirmed that there are always buckets of ice in the refrigerator, which is accessible 24/7 to staff and residents. Ms. Sanders confirmed that if a resident wanted ice yesterday, staff could have obtained it from the refrigerator, despite the freezer being locked in the pantry. Ms. Sanders denied any knowledge of Resident A not receiving a snack at night since she only works until 7:00 pm.

On 6/13/24, I spoke to AFC staff member, Benjila Green via phone. Ms. Green confirmed that she worked yesterday from 7:00 pm to 7:00 am. Therefore, she was not present at 4:00 pm when it was alleged that Resident A asked for ice and was told no. Ms. Green stated that she always gives Resident A what he asks for, including ice and snacks. Ms. Green stated that she is unable to speak for other staff members since she doesn't arrive to work until 7:00 pm. Ms. Green stated that when she came to work yesterday, she did observe a lock on the pantry, which is where the freezer is located. Ms. Green confirmed that the refrigerator did not have a lock on it. Ms. Green also confirmed that when she arrived on shift yesterday, she observed 2 buckets of ice in the refrigerator, which was accessible to all staff and residents. Ms. Green stated that the lock was added to the pantry just yesterday due to concerns of food missing. Ms. Green confirmed that this concern was related to staff as opposed to residents. Despite the lock being put on the pantry, Ms. Green confirmed that residents still have access to ice, water, food, and snacks all throughout the day. Ms. Green shared that when she arrived at work yesterday, she observed a fruit bowl to have apples, oranges, and bananas in it, which residents can have whenever they want.

Ms. Green was asked about Resident A reportedly asking for a snack at 7:00 pm and not receiving it until sometime after 11:00 pm. Ms. Green stated that when Resident A came to the kitchen/dining area yesterday, he initially "just sat there. He never asked me for a snack, he never said he needed anything. He just went back into his room." Later that night, Ms. Green stated that she did end up giving Resident A a peanut butter sandwich around 8:30 – 9:00 pm after she finished passing medications. She provided Resident A with the bread, and he made his own sandwich. Ms. Green was adamant that Resident A received his sandwich well

before 11:00 pm. Ms. Green denied Resident A having a scheduled time to receive a snack. Ms. Sanders stated that staff provide Resident A with snacks whenever he asks for them.

On 08/07/24, I conducted an exit conference with licensee designee, Mechelle Genigeski. She was informed of the investigative findings and denied having any 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:	Resident A stated that he did not receive ice on 6/12/24 and it took more than four hours to receive a snack when he asked. Ms. Abreu, Ms. Sanders, and Ms. Green all worked on the day in question, and each staff member denied the allegations or knowledge of it. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A is not receiving his 8:00 pm insulin medication as prescribed.

INVESTIGATION: On 6/13/24, I received a BCAL online complaint stating that Resident A is not receiving his insulin at 8:00 pm.

On 6/13/24, I spoke to the complainant via phone and she confirmed the allegation.

On 6/13/24, I made an unannounced onsite investigation at the facility. Upon arrival, I spoke to staff member, Erica Zoerhof regarding the allegation. Also present was licensee designee, Mechelle Genigeski. Mrs. Zoerhof stated that Resident A previously had two different types of insulins, and he was refusing one of them. As a result of Resident A refusing his second insulin, his doctor discontinued it around the end of May 2024. Ms. Zoerhof provided me with a copy of Resident A's MAR for the month of June, which indicated that his insulin is scheduled to be received at 8:00 am, 12:00 pm, and 5:00pm. It should be noted that Resident A is scheduled to have his blood sugar check at 8:00 pm, which is separate from his scheduled insulin doses. Per the MAR, Resident A's blood sugar is being checked daily as scheduled.

On 6/13/24, I spoke to Resident A regarding the allegation. Resident A stated his blood sugar levels are checked daily prior to staff administering his insulin. Resident A stated that he receives his insulin daily in the morning, after lunch, and just before dinner. This is consistent with Resident A's MAR as it is scheduled to be administered at 8:00 am, 12:00 pm, and 5:00 pm. Resident A stated that 7:45 am is the earliest he's received his insulin, and 8:45 am is the latest he's received it. I explained to Resident A that staff can administer scheduled medication up to one hour before the scheduled time, and one hour after the scheduled time. Resident A was understanding of this.

On 6/13/24, I spoke to staff member, Ani Abreu. Ms. Abreu was asked about Resident A not receiving his medication as scheduled. Ms. Abreu stated that she does not pass medications to residents as she is not trained. Therefore, she is unable to speak on whether Resident A receives his meds as scheduled.

On 6/13/24, I spoke to staff member, Vontrese Sanders via phone regarding the allegation. Ms. Sanders stated that Resident A receives his insulin in the morning and evening. Ms. Sanders was unsure if Resident A is scheduled to receive insulin at night because she leaves prior to night medications being administered. Ms. Sanders confirmed that Resident A always receives his medications as scheduled when she works.

On 6/13/24, I spoke to staff member, Benjila Green via phone. Ms. Green confirmed that Resident A is not scheduled to receive insulin at 8:00 pm. However, she added that his blood sugar levels are checked at 8:00 pm daily. Resident A's MAR confirmed this as well. Ms. Green stated that she occasionally works first shift. When she does, Resident A receives his insulin and other medications as prescribed.

On 08/06/24, I conducted an exit conference with licensee designee, Mechelle Genigeski. She was informed of the investigative findings and denied having any questions.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	All staff members interviewed confirmed that Resident A gets his insulin as scheduled, which is at 8:00 am, 12:00 pm, and 5:00 pm. This was confirmed on his MAR as well. Therefore, there is not a preponderance of evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION: While investigating the allegations listed above, I observed Resident A's MAR, which indicated that Resident A did not receive his Triamcinolon cream 0.1% and his insulin on 6/7/24 at 5:00 pm due to being "out of facility." Mrs. Zoerhof stated that Resident A's guardian took him to a walk-in dentist appointment to have his teeth pulled, which is why he didn't receive his meds on the day in question.

On 8/1/24, I left a voicemail for Mrs. Zoerhof requesting that she send me documentation confirming that Resident A left for an unplanned/emergency dental appointment to have his teeth pulled. Mrs. Zoerhof responded via text stating that Mrs. Genigeski would be sending me the requested documentation.

On 8/6/24, I received an email from Mrs. Zoerhof that included a resident sign-out log. The log shows that Resident A was signed out by a friend at 5:42pm and returned at approximately 7:00 pm. There was no documentation provided to show that Resident A was away from the facility with his guardian.

On 8/6/24, I conducted an exit conference with license designee, Mrs. Genigeski. Mrs. Genigeski agreed to review documentation and provide me with anything that would confirm that Resident A was away with his guardian during his scheduled med pass on 6/7.

On 8/6/24, I communicated to Mrs. Zoerhof and Mrs. Genigeski that the resident sign-out log that was submitted for Resident A does not suffice as it appears to show that he was in the facility during the time his medications were due and didn't receive them.

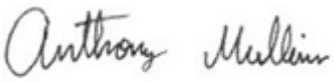
On 8/7/24, Mrs. Zoerhof sent me an email with a statement from her staff member, Melanie Chelette, indicating that Resident A didn't inform her when he left the facility on 6/7 at 5:42pm. Mrs. Zoerhof and I also spoke via phone, and I discussed Resident A receiving his medication prior to this time, as he is eligible to receive it up to one hour after it's due. Mrs. Zhoerhof is now aware that if a resident leaves the facility without informing staff during a medication pass, it will be considered a refusal as the resident didn't allow staff time to give them the medication to take while in the community. Mrs. Zoerhof did not have any documentation to confirm that Resident A was in the community with his guardian for an appointment on the day in question. Therefore, a corrective action plan is required within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.15312	**Resident medications**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	I requested documentation on 8/1/24 to confirm that Resident A did not receive his 5:00 pm medications as prescribed on 6/7/24 due to being away from the facility at a walk-in dentist appointment with his guardian. Staff were unable to provide the requested documentation. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the current license status.



08/07/2024

Anthony Mullins Date
Licensing Consultant

Approved By:

08/07/2024

Jerry Hendrick Date
Area Manager