GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 2, 2024

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

RE: License #: AM410384528
Investigation #: 2024A0583054
Alger Heights - South

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 #:	AM410384528
Investigation #:	2024A0583054
Complaint Receipt Date:	09/09/2024
Investigation Initiation Date:	09/09/2024
Report Due Date:	10/09/2024
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:	Alger Heights - South
Facility Address:	1025 28th St. SE Grand Rapids, MI 49508
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:	12
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff do not provide Resident A with adequate personal care.	No
Additional Findings	Yes

III. METHODOLOGY

09/09/2024	Special Investigation Intake 2024A0583054
09/09/2024	Special Investigation Initiated - On Site
10/02/2024	Exit Conference Licensee Designee Marcia Curtiss

ALLEGATION: Facility staff do not provide Resident A with adequate personal care.

INVESTIGATION: On 09/09/2024 I received complaint allegations via email from Adult Protective Services staff Kevin Souser. Mr. Souser stated that he is assigned to investigate the complaint allegations. Mr. Souser stated that the complaint alleged the following: *'(Resident A) (71) resides at Care Cardinal- Alger Heights. (Resident A) has been diagnosed with a history of COPD, neuropathy, and bi-polar disorder. (Resident A) does not have a legal guardian. (Resident A) requires assistance with her ADLs. On 09/06/2024 at about 7p, (Resident A) presented to the hospital for medical work up request by Care Cardinal. (Resident A) was observed to be lethargic, tired, and unresponsive. (Resident A) was also observed with a heavily soiled brief that appeared to have not been changed in a few days. (Resident A) has been asking the staff for help changing her because she requires assistance however, they have been refusing to help her. The staff have also been refusing to bathe (Resident A) and she has not been bathed in multiple days. The staff of Care Cardinal report that it is (Resident A) who is refusing to be changed or bathed.'*

On 09/09/2024 I completed an unannounced onsite investigation at the facility and privately interviewed Resident A, staff Sunantra Harris, and staff Aimee Nelson.

Resident A presented with appropriate hygiene and did not exhibit foul body odor. She was appropriately dressed. Resident A stated that she is her own legal decision maker and is "fighting depression". Resident A stated that she recently received medical treatment at Corewell Health Emergency Department due to "not feeling right" and was discharged quickly after her visit. Resident A acknowledged that she has been refusing assistance from facility staff with bathing. Resident A stated that

staff help her by offering showering assistance however she stated that she refuses their assistance. Resident A stated that she uses a wheelchair to ambulate but can transfer herself safety and walk short distances with a walker. Resident A stated that she can change her own adult brief, however facility staff do offer her assistance when she requests it.

Staff Sunantra Harris stated that Resident A often refuses to shower even after staff prompting. Ms. Harris stated that Resident A can change her own adult brief but will ring her “bell” when she requests staff assistance with changing her adult brief. Ms. Harris stated that she verbally reminds Resident A to change her own adult brief every hour, but Resident A typically refuses to use the toilet or refuses assistance from staff with changing her wet adult brief.

Staff Aimee Nelson stated that her position at the facility is titled as the facility’s Resident Care Manager. Ms. Nelson stated that Resident A was recently receiving in home services from Interim Hospice which included showering assistance. Ms. Nelson stated that Resident A often refused shower assistance from hospice staff. Ms. Nelson stated that Resident A was discharged from hospice services because she was deemed “no longer terminal”. Ms. Nelson stated that Resident A is offered showering assistance from facility staff but often refuses.

While onsite I reviewed Resident A’s Assessment Plan for AFC Residents, which was signed 05/30/2024. This document indicates that Resident A does not require staff assistance with toileting, dressing, and personal hygiene. The document indicates that Resident A does require staff assistance with bathing in the form of “assist x1” and grooming. The document does not indicate how Resident A is assisted with her grooming needs.

On 10/02/2024 I completed an Exit Conference via telephone with licensee designee Marcia Curtiss. Ms. Curtiss stated that she agreed with the findings.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A acknowledged that she has been refusing assistance from facility staff. Resident A stated that “staff help” her by offering showering assistance however, she refuses their assistance. Staff Sunantra Harris stated that Resident A often refuses to shower after staff prompting. Ms. Harris stated that Resident A

	can change her own adult brief but rings her "bell" when she wants staff assistance with changing her adult brief. Resident A's Assessment Plan was signed 05/30/2024 and indicates that Resident A does not require staff assistance with toileting, dressing, and personal hygiene. The document indicates that Resident A does require staff assistance with bathing in the form of "assist x1" and grooming. The document does not indicate how Resident A is assisted with her grooming. A preponderance of evidence was not discovered to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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

INVESTIGATION: On 09/13/2024 I received an email from Regional Executive Director Michelle Genigeski which contained Resident A's Medication Administration Record. I observed that Resident A's Medication Administration Record indicates that Resident A is prescribed Albuterol Nebulizer .083% four times daily which are administered at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. I observed that Resident A's Medication Administration Record indicates that Resident A missed said medication on 08/06/2024 at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM and missed said medication on 08/07/2024 at 12:00 PM, 4:00 PM, and 8:00 PM because "AWAITING MED ARRIVAL FROM PHARMACY". I observed that Resident A is prescribed "BUDES/FORMOT AER 160-4.5 INHALE 2 PUFFS BY MOUTH EVERY 12 HOURS" which is administered at 8:00 AM and 8:00 PM. I observed that said medication was not administered on 08/06/2024 at 8:00 AM and 8:00 PM, 08/07/2024 at 8:00 PM, and 08/08/2024 at 8:00 AM.

On 09/20/2024 I received an email from licensee designee Marcia Curtiss which stated that "Medications unavailable on August 6th, 7th, and 8th were ordered and delivered to the community on August 6th at 6:31pm".

On 09/20/2024 I received an email from licensee designee Marcia Curtiss. Ms. Curtiss acknowledged in the email that on 08/06/2027, 08/07/2024, and 08/08/2024 Resident A did not receive her "Albuterol NEB and Budes/Formot AER" as prescribed and that both medications were located "in the building but the staff failed to see it".

On 10/02/2024 I interviewed staff Jermelia Rowze via telephone. Ms. Rowze stated that she was assigned to administer Resident A's prescribed medications on the evening of 08/07/2024. Ms. Rowze stated that Resident A's prescribed Albuterol

NEB and Budes/Formot AER were not at the facility because Resident A had run out of the medications and staff were waiting for the medications to be delivered from the pharmacy. Ms. Rowze stated that Resident A did not receive her 08/07/2024 8:00 PM dosage of both medications and Ms. Rowze did not contact a medical provider to inform them of the missed dosages.

On 10/02/2024 I interviewed staff Gloria Taveras via telephone. Ms. Taveras stated that on 08/08/2024 she was assigned to administer Resident A's BUDES/FORMOT AER 160-4.5 at 8:00 AM however she could not locate the medication at the facility. Ms. Taveras stated that because the medication was missing, Resident A did not receive her 08/08/2024 8:00 AM dose of BUDES/FORMOT AER 160-4.5. Ms. Taveras stated that she notified medical staff at Home MD of the missed medication dose.

On 10/02/2024 I interviewed staff Chynia Johnson via telephone. Ms. Johnson stated that although Resident A's Medication Administration Records indicates that Ms. Johnson did not administer Resident A's Albuterol NEB and Budes/Formot AER on 08/06/2024 at 8:00 PM due to the medications "waiting on arrival from pharmacy"; Ms. Johnson stated that she did not work at the facility on that date. Ms. Johnson stated that Resident A's Medication Administration Record was inaccurate because she did not work at the facility on 08/06/2024 and does not know how her initials were documented in Resident A's electronic Medication Administration Record.

On 10/02/2024 I interviewed staff Vontrese Sanders via telephone. Ms. Sanders stated that she could not recall if she did or did not administer Resident A's ALBUTEROL NEB 0.083% on 08/06/2024 at 8:00 AM, 12:00 PM, and 4:00 PM and on 08/07/2024 at 12:00 PM and 4:00 PM and Resident A's BUDES/FORMOT AER 160-4.5 on 08/06/2024 at 8:00 AM. Ms. Sanders stated she always contacts an appropriate medical professional if a dose of medication is not administered.

On 10/02/2024 I completed an Exit Conference via telephone with licensee designee Marcia Curtiss. Ms. Curtiss stated that she will read the Special Investigation report and send over a Corrective Action Plan if she does not dispute the report's findings.

APPLICABLE RULE	
R 400.14312	**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:	Resident A's Medication Administration Record indicates that Resident A is prescribed Albuterol Nebulizer .083% four times daily which are administered at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Resident A's Medication Administration Record indicates that Resident A missed said medication on 08/06/2024 at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM and missed said medication on 08/07/2024 at 12:00 PM, 4:00 PM, and 8:00 PM because "AWAITING MED ARRIVAL FROM PHARMACY". Resident A is prescribed "BUDES/FORMOT AER 160-4.5 INHALE 2 PUFFS BY MOUTH EVERY 12 HOURS" which is administered at 8:00 AM and 8:00 PM. This medication was not administered on 08/06/2024 at 8:00 AM and 8:00 PM, 08/07/2024 at 8:00 PM, and 08/08/2024 at 8:00 AM. On 09/20/2024 I received an email from licensee designee Marcia Curtiss. The email correspondence from Ms. Curtiss acknowledged that on 08/06/2027, 08/07/2024, and 08/08/2024 Resident A did not receive her "Albuterol NEB and Budes/Formot AER" as prescribed and that both medications were located "in the building but the staff failed to see it". Staff Gloria Taveras stated that on 08/08/2024 she was assigned to administer Resident A's BUDES/FORMOT AER 160-4.5 at 8:00 AM however she could not locate the medication at the facility. Ms. Taveras stated that because the medication was missing, Resident A did not receive her 08/08/2024 8:00 AM dose of BUDES/FORMOT AER 160-4.5. A preponderance of evidence was discovered to substantiate violation of the applicable rule. Resident A is prescribed "Albuterol NEB" four times daily and "Budes/Formot AER" twice daily. Resident A's Medication Administration Record indicates that Resident A did not receive her prescribed "Albuterol NEB" on 08/06/2024 at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM and 08/07/2024 at 12:00 PM, 4:00 PM, and 8:00 PM. Resident A did not receive her prescribed "BUDES/FORMOT AER 160-4.5" on 08/06/2024 at 8:00 AM and 8:00 PM, 08/07/2024 at 8:00 PM, and 08/08/2024 at 8:00 AM.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Facility staff did notify an appropriate medical care provider after Resident A did not receive her prescribed medication.

INVESTIGATION: On 09/13/2024 I received an email from Regional Executive Director Michelle Genigeski which contained Resident A's Medication Administration Record. Resident A's Medication Administration Record indicates that Resident A is prescribed Albuterol Nebulizer .083% four times daily which are administered at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Resident A's Medication Administration Record indicates that Resident A missed said medication on 08/06/2024 at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM and missed said medication on 08/07/2024 at 12:00 PM, 4:00 PM, and 8:00 PM because "AWAITING MED ARRIVAL FROM PHARMACY". Resident A is prescribed "BUDES/FORMOT AER 160-4.5 INHALE 2 PUFFS BY MOUTH EVERY 12 HOURS" which is administered at 8:00 AM and 8:00 PM. This medication was not administered on 08/06/2024 at 8:00 AM and 8:00 PM, 08/07/2024 at 8:00 PM, and 08/08/2024 at 8:00 AM.

On 10/02/2024 I interviewed staff Jermelia Rowze via telephone. Ms. Rowze stated that she was assigned to administer Resident A's prescribed medications on the evening of 08/07/2024. Ms. Rowze stated that Resident A's prescribed Albuterol NEB and Budes/Formot AER were not at the facility because Resident A had run out of the medications and staff were waiting for the medications to be delivered from the pharmacy. Ms. Rowze stated that Resident A did not receive her 08/07/2024 8:00 PM dosage of both medications and Ms. Rowze did not contact a medical provider to inform them of the missed dosages.

On 10/02/2024 I completed an Exit Conference via telephone with licensee designee Marcia Curtiss. Ms. Curtiss stated that she will read the Special Investigation report and send over a Corrective Action Plan if she did not dispute the report's findings.

APPLICABLE RULE	
R 400.14313	**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 Jermelia Rowze stated that she was assigned to administer Resident A's prescribed medications on the evening of 08/07/2024. Ms. Rowze stated that Resident A's prescribed Albuterol NEB and Budes/Formot AER were not at the facility because Resident A had run out of the medications and staff were waiting for the medications to be delivered from the

	pharmacy. Ms. Rowze stated that Resident A did not receive her 08/07/2024 8:00 PM dosage of both medications and Ms. Rowze did not contact a medical provider to inform them of the missed dosages. A preponderance of evidence was not discovered to substantiate violation of the applicable rule. Staff Jermelia Rowze did not contact appropriate medical staff after Resident A did not receive a dose of her prescribed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend that the license remain unchanged.

10/02/2024

Toya Zylstra — Date
Licensing Consultant

Approved By:

10/02/2024

Jerry Hendrick — Date
Area Manager